Ministry of Health

Planning Handbook for the Ministry of Health: Health Centres, Health Posts and Communities

Sixth Edition
May 2011

Foreword

This planning handbook is one of a series that has been developed to provide planning guidance to districts, hospitals, Statutory Boards and training institutions. The handbook seeks to maintain simplicity while at the same time describing the planning process in detail to enable each level to produce an action plan that is generic for that level of care, so as to ensure uniformity of the plans. In order to enhance this process, the outline and cost guide sheets for the action plan will be provided electronically and will be distributed together with the handbook.

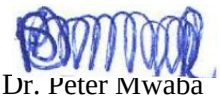
The revision of the handbooks has been done to provide further guidance on the preparation of results-oriented plans and activity-based budgets. This version of the handbooks also represents a shift away from disease/target group planning to service delivery mode planning in line with the marginal budgeting for bottlenecks methodology. Finally, we have incorporated in this version a strong monitoring and evaluation framework and guidance on encouraging community engagement in health planning.

The health centre/post priorities and objectives should be based on a solid analysis of their local health and environmental situations, previous experiences and performance assessments in line with the Medium Term Expenditure Framework requirements. Individual health centres/posts should conduct the bottleneck analysis to identify bottlenecks to achieving set objectives by individual health centres/posts. They should then carry out a review of the present local health situation in their environment from the HMIS reports.

Planning and budgeting under the MTEF should be resource-based, and allocation of resources should be in accordance with local priorities. However, the plans should be results or activity-based plans and budgets, and have clear and coherent links with both the National Health Strategic Plan and the National Development Plan to ensure that action plans in districts, hospitals, Statutory Boards and training institutions adequately reflect national priorities and development objectives.

The Provincial Health Offices have been given authority to launch and support the planning process in districts and hospitals each year. The Provincial Health Office should also evaluate the plans and sign a Memorandums of Understanding on behalf of the Ministry of Health. It is essential that the plan and budget for a health centre/post and community is inclusive of and consistent with the objectives and activities that may have been formulated for specific priority areas.

Appropriate planning forms are the basis of any system. I strongly appeal to each one to remain committed to the planning process as has been the case in the previous years.



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Permanent Secretary
MINISTRY OF HEALTH

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Glossary of Terms

Accreditation	The process by which an institution is objectively judged against pre-established standards in order to provide advice on needed improvements and public acknowledgement.
Activity	A specific action taken to achieve the objective.
Administrative Support	All activities and expenses related to the administration and general running costs not directly allocated to other cost centres, e.g., telephone, communications, salaries, etc.
Bottleneck Analysis	The planning or monitoring exercise to determine where impediments exist to reaching desired goals. These can exist on the levels of availability, accessibility, utilization, continuity and quality. Once bottlenecks are identified, interventions can be chosen to remove the blockage and improve outcomes.
Budget	A quantification of the resources and the associated costs of implementing the plan within a defined time period.
Clinical Care Costs	All costs related to activities associated with patient care.
Clinical Teaching	Teachings done to correlate theory with practice in the practicum setting.
Community Engagement	A deliberate process of working with and involving community in planning for health interventions related to their own identified health needs but based on the Ministry of Health priority areas.
Curative	Actions that reduce or eliminate the impact of illness. They include the early diagnosis and initiation of treatment.
Curriculum	All planned learning experiences to be covered within a specified period of time by learners.
Interventions	Detection and the prompt and effective treatment of illness.
Health Promotion	The process of using information, education and communication, and community mobilisation to positively influence the health behaviour of individuals and groups.
Hospital Support to Health Centres	All activities and expenses related to technical support, in-service training, and clinical care provided by hospitals to health centres.
Indicator	An observable measure of the progress made towards achieving an objective.

Inflation	Sustained increase in prices and a corresponding fall in the purchasing value of money.
In-Service Training	All activities related to retraining and orientation of existing staff.
Indicative Planning Figure	This is the projected level of funding anticipated for the next year.
Medium Term Expenditure Framework	Planning expenditure framework that provides budgetary information for the next three years of the health sector.
Monitoring	The process of regularly collecting and analysing information about the implementation of a plan to identify problems and take corrective action.
Objective	The desired end result of a set of actions. An objective should state clearly what is to be achieved and must be measurable (to see if it has been achieved).
Plan	The definition of what is to be achieved (objectives), how it is to be achieved (activities), and the resources (people, materials and money) needed for implementation.
Pre-service Training	The basic course of training which leads to accreditation as a member of a profession.
Prevention	Actions taken to preserve health. Primary prevention is intended to reduce the incidence of disease and injury.
Priority	The most important thing. In planning, a priority might be a problem or a solution (intervention).
Programme	Within the planning handbooks, a programme is a classification of activities based upon what the planned activities are intended to influence. For example, malaria is a programme, therefore all planned activities intended to influence the malaria situation would be classified under the malaria programme.
Rolling Plan	This is a plan of a continuous nature, e.g., the MTEF. The MTEF is a rolling plan with a three-year planning framework/cycle, where the planning time is of a continuous nature. Continuity exists because each year a detailed annual plan is prepared for the next year as one year is dropped and another one added, and the three-year timeframe is therefore continuous.
Strategy	A planned approach for achieving an objective. A strategy tells you how the objective will be achieved and provides a guide for the selection of specific activities to be carried out.
Supportive Supervision	The process of monitoring and reviewing achievements with the purpose of providing the necessary supportive guidance and assistance to promote continuous performance and quality improvement.

Technical Support	Clinical or management guidance, advice and assistance provided to other levels in the health system.
Training Institute	A centre in the health sector which provides education and training for health.

Abbreviations

ABB	Activity-Based Budgeting
ACT	Artemisinine-Based Combination Therapy
AFB	Acid-Fast Bacillus
AFP	Acute Flaccid Paralysis
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
BCC	Behaviour Change Communication
BCG	Bacillus Calmette-Guérin (TB vaccination)
BTL	Bilateral Tubal Ligation
CBO	Community Based Organisation
CBOH	Central Board of Health
CDE	Classified Daily Employee
CIP	Capital Investment Plan
CP	Cooperating Partner
CSO	Central Statistical Office
CTC	Counselling, Testing and Care
DAO	District Accounting Office
DDCC	District Development Coordinating Committee
DHAC	District Health Advisory Committee
DHB	District Health Board
DHIO	District Health Information Office
DHIS	District Health Information System
DHO	District Health Office
DOTS	Directly Observed Treatment Short Course
DPT	Diphtheria, Pertussis, Tetanus
DSA	Daily Subsistence Allowance
EHT	Environmental Health Technologist/Technician
EMONC	Emergency Obstetric and Newborn Care
ENT	Ear, Nose, Throat
EOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunisation
FBO	Faith Based Organisation
FP	Family Planning
GRZ	Government of the Republic of Zambia
HAART	Highly Active Antiretroviral Therapy
HAC	Hospital Advisory Committee
HAHC	Hospital Affiliated Health Centre

HB	Hospital Board
HC	Health Centre
HCC	Health Centre Committee
HCAC	Health Centre Advisory Committee
HCPT	Hospital Core Planning Team
HIA	Health Information Aggregation
HIS	Hospital Information System
HMIS	Health Management Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMT	Hospital Management Team
HP	Health Post
HPMF	Health Performance Monitoring Framework
HRHSP	Human Resource for Health Strategic Plan
IDA	International Dispensary Agency
IPF	Indicative Planning Figure
IPT	Intermittent Presumptive Treatment
IRH	Integrated Reproductive Health
IRS	Indoor Residual Spraying
ITGs	Integrated Technical Guidelines
ITN	Insecticide Treated Mosquito Net
IUD	Intra-Uterine Device
LCP	Local Cooperating Partners
LFA	Logical Framework Approach
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal Child Health
MDGs	Millennium Development Goals
MOFNP	Ministry of Finance and National Planning
MOH	Ministry of Health
MOV	Means of Verification
MOU	Memorandum of Understanding
MSL	Medical Stores Limited
MTEF	Medium Term Expenditure Framework
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organisation
NHC	Neighbourhood Health Committee
NHSP	National Health Strategic Plan
OI	Opportunistic Infection
OPD	Out-Patients Department
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
PA	Performance Assessment
PAC	Post Abortion Care
PEs	Personal Emoluments

PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PHO	Provincial Health Office
PLWHA	Person Living with HIV/AIDS
PMO	Provincial Medical Office
PMTCT	Prevention of Mother-to-Child Transmission
RPR	Rapid Plasma Reagent
STI	Sexually Transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TBA	Traditional Birth Attendant
TI	Training Institution
TS	Technical Support
TSS	Technical Support Supervision
UCI	Universal Child Immunisation
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
ZISSP	Zambia Integrated System Strengthening Programme
ZDHS	Zambia Demographic and Health Survey
ZEM	Zambia Enrolled Midwife
ZEN	Zambia Enrolled Nurse

1. Introduction

1.1 The Health Reform Vision

The vision of Zambia's health reform is to provide equity of access to cost-effective, quality health care as close to the family as possible. The strategy adopted to achieve this vision emphasises integrated delivery of cost-effective interventions that address the majority of health problems affecting the Zambian population. By decentralising and integrating services, and by shifting emphasis to health centre and community level interventions, costs will be contained while improving accessibility and quality of care.

Consistent with this vision, great emphasis is placed on the work of the district to deliver the Zambian Health Care Package which has been defined for the purpose of improving the overall health status of the Zambian people. Therefore, thoughtful planning and budgeting for these services are essential to make delivery possible and sustainable.

In 2003 the Government decided to shift the public sector planning process to a Medium Term Expenditure Framework (MTEF) with three-year rolling plans. The public sector as a whole and the Ministry of Health (MOH) in particular, adjusted its annual planning process to meet MTEF objectives, which are to:

- Ensure efficient allocation and management of public resources;
- Develop and maintain fiscal discipline in planning and management of public resources;
- Ensure commitment to budget priorities at national and sector levels;
- Improve accountability for national resources;
- Increase predictability of resources;
- Improve the procurement system.

The Ministry of Finance and National Planning (MOFNP) now provides budget ceilings for three years under the MTEF to allow ministries, provinces and spending agencies to develop plans within an available resource envelope. Thereafter, the MOH provides the strategic focus (derived from the National Development Plan and the National Health Strategic Plan), technical planning guidelines and budget ceilings to all health institutions annually. This information is used alongside other locally generated information from such sources as Health Management Information System (HMIS) and performance assessment reports to prepare action plans. However, health centres/posts are only required to prepare annual activity plans and budgets that incorporate community plans and budgets.

1.2 Rationale

The last revision of the planning handbooks, which incorporated guidelines for planning on HIV/AIDS activities, was undertaken in 2005. Since then, improvements have been recorded in the quality of district and hospital action plans though there is still room for improvement.

A number of planning issues as well as approaches have emerged, making it necessary to undertake a fresh revision to the planning handbooks. This revision is aimed at strengthening current planning guidelines to ensure effective planning for key public health programmes, including guidelines for community engagement. Furthermore, the MOH has adopted fresh approaches to planning such as Marginal Budgeting for Bottlenecks (MBB) and Health Performance Monitoring Frameworks (HPMF) which place more emphasis on outcomes and outputs rather than inputs and processes. The major purpose of this revision, therefore, is to incorporate these issues and approaches into planning handbooks for all

levels (district, hospital, health centre, training institution and Statutory Boards). An annex of high impact interventions adopted from the MBB approach has been inserted into this handbook (*see Annex 3*).

1.3 Purpose of this Handbook

Effective planning is cardinal to the realisation of the objectives of the National Development Plan as well as the National Health Strategic Plan. This handbook has been prepared to provide planning guidance and information to health centres/health posts and communities for use in the process of developing action plans.

The health centre plans should be based on national priorities and an analysis of the local health situation. This forms the basis for the identification of local priorities as well as the development of cost effective interventions which are responsive to the local health needs of the society. The handbook is periodically revised within the framework of the National Health Strategic Plan when need arises.

The handbook is not intended to incorporate programmatic or financial guidelines which are subject to more frequent changes which can be found in documents such as the:

- Basic Health Care Package;
- Integrated Technical Guidelines;
- Quantification of Medical Supplies Manual;
- Designing and Operating Cost Sharing Schemes for Health Care;
- District Health Financial Planning Guide (updated annually); and
- Hospital Financial Planning Guide (updated annually).

2. The Health Centre and Planning

2.1 Roles of the Health Centre

The major roles of the health centre include:

- Provision of promotive, preventive, curative and rehabilitative services;
- Provision of technical backup services to the health posts; and
- Provision of first contact treatment in the catchment area where there are no health posts.

In relation to planning, the health centre's roles include the following:

- The health centre will work with the District Health Office (DHO) team and the Health Centre Advisory Committees (HCACs) to select appropriate interventions to include in the action plan.

2.2 Annual Planning Schedule

Table 2.1 provides guidance on when each step in the annual planning process should have been undertaken and completed. The same information is provided in Table 2.2 in form of a Gantt chart. ***The activities presented in the shaded boxes (in Table 2.1 and those presented in bold) are those which directly involve action by the health centre.*** Each of the activities listed in the schedule is then described in detail in Section 3.

Table 2.1: Annual Planning Schedule

Activity	Timeline
1. MOH headquarters gives Provincial Health Offices (PHOs) information on financial ceilings, technical planning guidelines and HMIS analysed data for the previous year.	1st wk. May
2. PHO meets with DHOs and hospitals to review programme guidance and provide other updates (Step 1).	3rd wk. May
3. DHO meets with the District Health Advisory Committees to review the previous year's experiences and to obtain their inputs for the next year's plan (Step 2).	4th wk. May
4. DHO meets with hospitals providing first level referral services to negotiate bed purchase and agree on the terms of the Memorandum of Understanding (MOU) (Step 3).	4th wk. May
5. DHO briefs first level hospitals, health centre/health post in-charges on programme and any planning updates (Step 4).	**4th wk. May**
6. Health centres meet with community representatives to review achievements and problems and to brief on any updates.	**1st wk. Jun**
7. Community representatives meet with community to review experiences, determine priorities and to agree on community actions.	**2nd wk. Jun**
8. Community representatives meet with health centre staff to draft community action plan.	**3rd wk. Jun**
9. 2nd/3rd level hospitals meet with their Health Advisory Committee to review progress in the first half year and to receive their input for the next year's plan.	2nd wk. Jun
10. Hospitals form core planning teams which brief their departmental heads.	3rd wk. Jun
11. DHO meets with health centres, hospitals, health training institutions and NGOs to draft plans (Step 5).	**1st wk. Jul**
12. Health centres meet with community representatives to provide feedback on the projected budget and final community action plan.	**3rd wk. Jul**
13. Core hospital planning teams meet departmental heads to review next year's departmental allocations and planning launch.	2nd wk. Jul
14. Hospital departments draft their plans and submit to hospital core planning team.	4th wk. Jul
15. 2nd/3rd level hospitals present their plans to the Hospital Advisory Committee and first level hospitals submit their completed plans to DHO.	1st wk. Aug
16. 2nd/3rd level hospitals present their plans to the PHO; first level hospitals present their plans to their DHO.	2nd wk. Aug
17. DHO drafts the DHO plan (training, supervision, advisory committee expenses, epidemic preparedness, etc.) (Step 6).	2nd wk. Aug
18. DHO consolidates district action plan and budget (Step 7).	4th wk. Aug
19. DHO presents and defends the district health plan and budget to the Health Advisory Committee and District Development Committee (Step 8).	1st wk. Sept
20. DHO submits the district action plan to the District Commissioner.	2nd wk. Sept
21. DHO submits the district action plan to the PHO (Step 9).	2nd wk. Sept
22. PHO reviews district, training institution, 2nd and 3rd level hospital plans and institutions which then revise/finalise their plans and resubmit to PHO (Step 10).	3rd wk. Oct
23. Provinces approve plans, sign MOUs and submit consolidated copies of district, training institutions and 2nd/3rd level hospital plans to MOH.	3rd wk. Oct
24. MOH headquarters consolidates and submits health sector plan and budget to MOFNP.	1st wk. Nov

Table 2.2: Planning Schedule Gantt Chart

Action	May				June				July				August				September				October				November			
1. MOH gives financial ceilings for the three-year plan to the PHO																												
2. PHO meets with DHOs/hospitals to provide updates																												
3. DHO meets with DHAC to review past year's experience																												
4. DHO negotiates purchase of first level referral services																												
5. DHO briefs health centres/ posts on programme/ planning updates																												
6. Health centres meet with NHCs/Health Centre Committees (HCCs)																												
7. NHCs/HCCs meet with community members																												
8. NHCs/HCCs meet with health centre to draft community action plans																												
9. 2nd/3rd level hospitals meet with their hospital boards																												
10. Hospitals form core planning teams																												
11. DHO/health centres meet to define district objectives and health centre plans																												
12. Health centres meet with NHCs/HCCs to give feedback on plans																												
13. Health core planning teams meet with departmental heads to launch planning																												
14. Hospital departments draft their plans																												

Action	May				June				July				August				September				October				November			
15. Health centre core planning team produces hospital plan and presents to hospital management																												
16. $2^{nd}/3^{rd}$ level hospitals present plans to PHO; first level to DHO																												
17. DHO prepares DHO plan																												
18. DHO produces consolidated district action plan and budget																												
19. DHO presents district action plan to District Health Board for approval																												
20. DHO submits consolidated district action plan to PHO																												
21. PHO reviews district and $2^{nd}/3^{rd}$ level hospital plans																												
22. DHOs/ hospitals/training institutions revise plans and re-submit finals to PHO																												
23. PHOs approve district/hospital/training institution plans, sign MOUs and send to MOH headquarters																												
24. MOH headquarters consolidates and submits health sector plan and budget to MOFNP																												

Note: The steps in bold are those for which the health centre is directly responsible.

3. Planning Steps for Each Year

The following steps are suggested to guide health centre teams and health post staff in their planning and to help them ensure that key players in implementation are fully involved at the planning stage.

Detailed guidelines for community engagement are provided in annex 10.

Step 1: Meeting of the Health Centre/Health Post In-Charge with the District Health Office Team

Every year during the first week of July, the DHO team will meet with the health centre in-charges and health post officers to update them on any new programmatic guidance and information that may have been received from MOH headquarters, including the national goals and priorities as derived from the National Development Framework and the budget ceilings.

This information will assist health centre and health post staff to complete the plan with their communities. During this meeting, the DHO team will also provide guidance to the health centre and health post staff on steps that need to be taken to ensure that minimum quality standards are achieved. Using the HMIS reports and data submitted by the health centres, the DHO team will outline the prevailing health situation in the district.

Step 2: Meeting with Community Representatives

The health centre or health post staff should then meet with representatives of the communities they serve and community-based organisations (CBOs). This can be done through the HCAC or through other community organisations that are available.

The purpose of this meeting is to:

- Review priority areas identified in line with updates received from the HCAC;
- Identify lessons learned from past experience;
- Provide guidance to the community representatives on how they should help their communities to determine the most important health problems that the community wants to tackle in the next year, to agree on priorities and to identify actions that the community would be willing to take to tackle these problems; and
- Identify local resources that could be used to support implementation of these activities.

A possible agenda for this meeting is as follows:

1. Start with reviewing priority areas identified in line with updates received from the HCAC;
2. Review the effective interventions that the community could take to tackle the problems identified *(refer to Annex 3 for suggested high impact interventions and "Integrated Technical Guidelines for Frontline Health Workers (ITGs) Third Edition," for information about effective interventions that the community can carry out).* This information will help the community representatives to help the community to decide what they could do next year;
3. Review with the community representatives a possible agenda for their meeting with the community (*see Step 3 below*) so that they can prepare themselves;
4. Provide community representatives with financial information based on the existing budget ceilings which they should share with community members during their planned meeting; and

5. HCAC members to set dates for meetings with their respective community groups to give financial information and other technical updates for the community to complete their action plan for the following year.

Step 3: Community Representatives Meet with Community Members

The purpose of this meeting is for the community representatives to seek the participation of community members and community-based agents in deciding what the community should plan to do next year.

A possible agenda for this meeting is as follows:

1. The community representatives should start with a review of the community's priority plans in line with the updates received. They should then review what more is likely to be achieved by the end of the year.
2. The community representatives should then lead a discussion on what the five most important (in the community's view) health problems are that the community is facing. If the issue of HIV/TB, malaria, maternal and newborn care and child health problems have not been mentioned, community representatives should find out what community members think and how they have handled the problem at community level. These should be listed in order of priority (based on the community's perceptions about which are the most common and the most serious in their community).
3. The community representatives should then review the effective interventions that the community could take to tackle the problems identified and should help the community members reach a decision on what the community would be willing to undertake in the next year *(please refer to Annex 3 "High Impact Interventions" and the ITGs booklet).*
4. The community representatives should then lead a discussion on what resources are available in the community that could contribute towards solving the identified problems.
5. The community representatives should then help the community to identify the actions that the health centre and others (e.g., non-governmental organisations [NGOs]) will need to take to support the community's action plan.
6. The community representatives should then finish the meeting by informing the community that the action plan may have to be adjusted if there are any changes to the current funding level. Therefore, community representatives should provide feedback to that effect.

Step 4: Health Centre Meets with Community Representatives to finalise Drafting of the Community Action Plan

On the agreed date, the health centre/health post staff should hold their third meeting with the community representatives. At this meeting, the community representatives will give feedback to the health centre/health post staff on community decisions on priority problems and on what the community will be able to do in the following year. At this meeting, the health centre/health post staff should work with the community representatives to draft the community action plan. Costing of the community action plan should not be completed at this stage, but will be done in Step 5 with the help of the DHO team.

Health centre/ post representatives should prepare the following information in readiness for the meeting with the DHO:

- HMIS data for the previous year;
- Performance assessment report for the same period;
- Results of the bottleneck analysis (*see Annex 1 for a description of the bottlenecks analysis*); and

- A set of health priorities based on the analysis of the routine health information system and the bottleneck analysis. This analysis will explore the underlying causes of these problems, to ensure that there is proper understanding of the problem and to determine actions to be taken. Box 3.1 below outlines the main elements of a situation analysis.

Box 3.1: Contents of Situation Analysis

Population characteristics
- Demographic information
- Religious, educational and cultural characteristics

Area characteristics and infrastructure
- Geography and topography
- Infrastructure and socio-economic situation
- Public and private sector structures

Policy and political environment
- National and health policies
- Political environment

Health needs
- Medically perceived (HMIS)
- Community perceived

Health services
- Facilities and utilisation
- Service gaps
- Service organisation

Resources
- Financial and personnel
- Buildings, equipment and vehicles
- Drugs and medical supplies

- Determination of the total resource envelope based on ceilings provided by the district, pledges from local donor projects and projections of user fee collections where applicable.

Step 5: Meeting with the District Health Office Team to Draft Health Centre Plan

The health centres, health posts, hospitals, health training institutions, local NGOs, other stakeholders such as the District HIV/AIDS task forces and faith-based organisations (FBOs), will attend a meeting called by the DHO. During this meeting, the health centre/ post staff will share the results of the health analysis and identified priorities. The district will tap the stakeholder inputs into the district plan and agree on the district wide objectives. Health centres and health posts should take with them the draft community action plans completed earlier, together with the self-assessment forms for the previous year.

During the first part of this meeting, the DHO will lead participants in the following tasks:

Identifying outputs and high impact interventions

The DHO with the health centre and health post staff decide on the priority health problems that the district wishes to focus on in the following year. Based on this, they should agree on realistic objectives for each of the health problems defined as general district priorities for the next MTEF, so that all the health centres can determine activities which will help the district achieve these objectives.

The next step will be to identify high impact interventions to address the health challenges prevailing in the district.

Costing and budgeting of the plan
The health centres with guidance from the district should then start costing the identified interventions using the following steps.

1. Defining the scope of the costing exercise
This stage involves selection of the implementation strategy. For example, for malaria prevention interventions, there should be an indication whether emphasis will be placed on distribution of insecticide treated bed-nets (ITNs) or indoor residual spraying (IRS).

2. Identification and description of programmes and activities
This step involves selection and description of the programmes and activities to be implemented at community level as outreach programmes and health centre-based (*please see Annex 3).* For each of the identified programmes, it is necessary to state the geographical spread.

3. Identification of inputs

This stage looks at identifying the inputs needed to carry out an activity. The inputs needed to carry out an immunization campaign for example, might include staff, transport costs, subsistence or per diem payments, vaccines and syringes, cold chain equipment, publicity materials, immunization records and staff training *(see Table 3.1)*. The district management team must carefully identify all the major and relevant items of expenditure needed to carry out activities identified in Step 2. The MOH headquarters has provided a well-designed chart of accounts in *Annex 8,* detailing and segregating costs in line with designed cost centres. The most common expenditure items include:

Table 3.1: Identification of Inputs

1 Staff allowances	5 Water	9 Travel
2 Drugs/other medical supplies	6 Stationery	10 Seminars and meetings
3 Transport and vehicle running costs	7 Cleaning materials	11 Bank charges
4 Electricity	8 Repairs	12 Linen

Recurrent inputs are resources that are used up and consumed within a year of purchase (e.g., drugs, educational materials, labour). *Capital goods* are items such as vehicles, equipment and buildings that have a useful life of longer than one year. Capital items are one-off (in the short to medium term) while recurrent items continue to occur as part of the operations of the activity.

4. Developing an activity based cost framework
Each of the cost dimensions (activity, inputs, funding source, level of operation, etc.) can be broken down or sub-divided in different ways and with different levels of detail. Table 3.2 illustrates this for each of the dimensions of inputs, activities, level of operation and source of funds.

Table 3.2: Cost Framework for Health Centre Level Activities

Programme	Activities	Inputs		Source of Funding	
		Recurrent	Capital	Domestic	Donor
Family and community-based services	ITNs; IRS; malaria treatment with community drug kits	Staff costs, supplies, fuel, etc,	Boats, bicycles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources
	Complementary and supplementary feeding; vitamin A supplementation	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources
	Oral rehydration, water treatment and hygiene education	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources
Schedulable and outreach services	Family planning; antenatal (ANC) care; de-worming, vitamin A and iron supplementation in pregnancy, malaria intermittent presumptive treatment (IPT); prevention of mother to child transmission (PMTCT) of HIV	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources
	Immunizations; vitamin A supplementation	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources
	Condom use, behaviour change communication	Staff costs, supplies, fuel, etc.	Boats, bicycles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources
Clinical care (health centre in-house care)	Skilled delivery care; basic emergency obstetric care (EmONC);	Staff costs, supplies, fuel, etc.	Vehicles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources
	appropriate treatment for malaria (or Artemisinine-based combination therapy [ACT]); Directly Observed Treatment Short-Course (DOTS) for TB	Staff costs, supplies, fuel, etc.	Vehicles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources
	Complicated malaria; anti-retroviral therapy (ART); management of (pre) eclampsia; comprehensive EmONC	Staff costs, supplies, fuel, etc.	Vehicles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources

Programme	Activities	Inputs		Source of Funding	
		Recurrent	Capital	Domestic	Donor
Health system management	Performance assessment, supervision, utilities, other admin. costs	Staff costs, supplies, fuel, etc.	Vehicles, motorbikes, buildings and equipment	Government / medical fees and other charges	Basket, project and other sources

It is up to the individual health centres/posts to identify the activities under each programme for inclusion in the costed plan. Whatever the details of the categories within each dimension, there are certain points to bear in mind. It is essential that the classification is comprehensive. There must be a "home" for each relevant cost, meaning each item must be placed within a specific cost centre. The classification should also be mutually exclusive. Within any given organising principle, a particular cost should only have one "home."

The end product of this step is a cost framework that identifies the cost dimensions that will be focused on and how much detail and cross-linking of data there will be, as well as a list of key activity categories categorized as either primary, secondary or ancillary activities with a description of what each involves and an indication of how the activities relate to each other and to outcomes.

5. Determination of input unit costs and quantities

The next step involves collecting data on unit costs of the various cost items to facilitate expressing the resources identified in monetary terms. Information for this stage can be obtained from existing budgeting and accounting systems, i.e., books of accounts, payroll and fixed assets register, etc. The district management will assist in sourcing information on the cost of inputs.

Having derived unit costs of various inputs, the next stage will be to determine the quantity of inputs required to undertake the identified activities at the required scale. This determination will take into account the current operational levels as well as the planned scale-up if any. The data can then be collated into the basic tables of the **cost framework**. These tables will reveal the cost of different elements of the programme as well as the programme's total costs.

In completing the cost framework for the district, the health centre should take note of the following points:

- Refer to the community action plan that they helped the community representatives to complete on Worksheet D. The DHO can help calculate the cost of each activity and determine whether all these activities can be afforded out of next year's funds for community-based activities.
- Remove lower priority activities from the community action plan if total cost exceeds what is available. If some activities have to be excluded, start a new Worksheet D for the community action plan and enter only those activities that can be afforded, together with the relevant costs. Each health centre/post should keep a copy of the original draft community action plan to facilitate feedback to community representatives at a later date.
- Refer to the Basic Health Care Package or the ITG for Frontline Health Workers (Third Edition) and the list of high impact, evidence-based interventions for selection of appropriate interventions. Discuss any other ideas they may have which may not be included in the ITGs booklet with the DHO. When they have decided what they can do, enter details of the activity and costs on Worksheet D.

4. Monitoring the Implementation of the Plan

The health centre/post will be required to monitor the implementation of its plan and to report on progress being made towards achievements of the defined objectives in line with the planned activities. To do this, the health centre/post should build in a monitoring and evaluation plan within their health centre/post plan to facilitate monitoring of the implementation process on a quarterly basis (*see monitoring format in Annex 5).* This information will also be used during the preparation of the annual report. The health centre will be expected to submit quarterly and annual progress reports to the DHO for consolidation and onward submission to MOH headquarters.

At the end of the year, each health centre/post will be expected to provide a report on how they have managed, what impact this has had on the expected outcomes, and make recommendations for the future.

Each quarter, the health centre and health post should produce updated quarterly summary action plans and budgets which take into account HMIS reports and the performance reports of the previous quarter.

As part of its monitoring responsibility, the health centre/ post should prepare short reports each quarter to identify the progress that has been achieved in terms of implementation. The reports should be shared with health post/centre and first level hospital staff during supervisory visits or meetings.

The questions that need to be answered during monitoring are as follows:

A. With reference to the original health centre/health post activity plan and schedule:

i. Have the planned activities been implemented at the intended time and by the designated person/s? If not, why?

ii. Should activities that have not been implemented be re-scheduled?

B. With reference to the district-wide objectives:

i. Are the activities implemented achieving the desired result(s)? (Reference should be to the quarterly self-assessment form, updated quarterly summary plans and performance assessment reports.)

C. With reference to the planned activities (A) and to the district objectives (B):

i. Given the experience to date, do any of the planned activities need to be adjusted, re-scheduled or cancelled?

Should any additional activities now be programmed so that the desired results can be achieved?

The health centre/post should prepare an annual report (during the first quarter of the following year) which compares progress on planned objectives and constraints experienced during the year, and recommendations on the way forward.

5. Format of the Health Centre Action Plan

The following is the format of the health centre action plan.

Part 1: Introduction

1.1 Name of Health Centre/Post

1.2 Location of Health Centre/Post

State where the health centre/post is located in the district, distance from the DHO and nearest referral hospital and means of access to them.

Part 2: Health Centre Profile

Table 2.1: Catchment Population and Key Health Indicators

Category	N-2		N-1		N	
	Number	%	Number	%	Number	%
Children 0 – 11 months						
12-59 months						
5+ years						
Women 15 – 49 years						
Total males						
Total females						
Total population[\1]						
Population growth rate						
Expected pregnancies						
Expected deliveries						
Expected live births						

[\1] State whether source is from Central Statistical Office (CSO) or other source.

2.1 Socio-Economic Profile

Provide a brief description of major industries, employment opportunities, main occupations of the population, lifestyles, schools, population movements, levels of wealth/poverty, literacy rates for males and females, women's status and other factors limiting development.

2.2 Stakeholders, Government Departments and Other Health Providers

Give a brief description about stakeholders, government departments and other health providers and the type of services/support they are providing.

Table 2.2: Stakeholders in the Health Sector

Organisation	Catchment Area	Programme Focus and Activities

Part 3: Situation Analysis

3.1 Health Status

- Provide details for the top 10 causes of morbidity for Tables 3.1.1 and 3.1.3 and mortality for Tables 3.1.2 and 3.1.4. The list of diseases in the tables should not be pre-populated as they may change by year;
- Write briefly about the top ten by year;
- In Tables 3.1.2 and 3.1.4, list the top 10 according to volumes/number of people who died;
- When calculating the contribution in percentage for Tables 3.1.2 and 3.1.4, correct to one decimal point.

Table 3.1.1: Top Ten Causes of Morbidity (All Ages)

No.	Year 1				Year 2				Year 3			
	Disease	Incidence/1000			Disease	Incidence/1000			Disease	Incidence/1000		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

Table 3.1.2: Top Ten Causes of Mortality (All Ages)

No.	Year 1				Year 2				Year 3			
	Disease	Number Dead			Disease	Number Dead			Disease	Number Dead		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

Table 3.1.3: Top Ten Causes of Morbidity (Under 5s)

No.	Year 1				Year 2				Year 3			
	Disease	Incidence/1000			Disease	Incidence/1000			Disease	Incidence/1000		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

Table 3.1.4: Top Ten Causes of Mortality (Under 5s)

No.	Year 1				Year 2				Year 3			
	Disease	Number dead			Disease	Number dead			Disease	Number dead		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

Table 3.1.5: Top Ten Causes of Morbidity (5+ Years)

No.	Year 1				Year 2				Year 3			
	Disease	Incidence/1000			Disease	Incidence/1000			Disease	Incidence/1000		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

Table 3.1.6: Top Ten Causes of Mortality (5+ Years)

No.	Year 1				Year 2				Year 3			
	Disease	Number dead			Disease	Number dead			Disease	Number dead		
		Male	Female	Total		Male	Female	Total		Male	Female	Total
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

Table 3.1.7: Nutrition Status of Under 5s

Indicator	Year $^{N-3}$			Year $^{N-2}$			Year $^{N-1}$		
	No. <5s	No. Weighed	%	No. <5s	No. Weighed	%	No. <5s	No. Weighed	%
Total number of children weighed out of total < 5s									
No. of children below lower line (-3 Z scores) 0-23 months									
Vitamin A supplements for 6-59 months									
De-worming for 12-59 months									

Note: To do this, determine the number of <5s weighed during the period under review out of the expected total of <5s in the district. From this number, calculate how many of those were below the lower line and the percentage this would be.

Table 3: 8: Notifiable Diseases

Notifiable Disease	Year		
	N-1	N-2	N-3
Acute Flaccid Paralysis			
Anthrax			
Cholera			
Dysentery			
Measles			
Meningitis			
Neonatal tetanus			
Typhoid			
Yellow fever			
Plague			
Dog bite			
Rabies - Confirmed			
Smear Positive TB			

In this table provide information on any outbreaks experienced during the year in the key notifiable diseases.

3.2 Service Coverage

3.2.1 Child Health Interventions

Provide information on immunization and vitamin A coverage.

Table 3.9: Immunisation/Vitamin A Coverage

	N QTR 1& 2			N-1			N-2			N-3		
Antigen	**Target**	**Covered**	**%**	**Target**	**Covered**	**%**	**Target**	**Covered**	**%**	**Target**	**Covered**	**%**
BCG												
OPV0												
OPV1												
OPV2												
OPV3												
OPV4*												
DPT+Hib+Hep 1												
DPT+ Hib+Hep 2												
DPT+ Hib+Hep 3												
Measles												
Fully immunized (0-11 months)												
Vitamin A (0-5 months) non-breastfeeding babies												
Vitamin A (6-59 months)												

* OPV4 is given at 9 months if OPV0 was not given.

Note: If the coverage figures appear higher than expected, the district should indicate whether this is due to serving populations which are not included in the Population Table.

3.2.2 Integrated Reproductive Health

- In Table 3.2.2 provide integrated reproductive health (IRH) coverage figures by service for a three year period.
- Youth is defined as 10-24 years. Each district should use their own data to come up with their targets for these areas.

Table 3.2.2: Integrated Reproductive Health Coverage by Year

Service	N-1		N-2		N-3	
	Target	**No. attended to**	**Target**	**No. attended to**	**Target**	**No. attended to**
1. Focused antenatal care						
First ante-natal attendance						
Average ante-natal visits per pregnant woman						
Rapid plasma reagent (RPR) tested						
RPR reactive						
Partners treated for sexually transmitted infections						
TT protection						
Folic acid and iron						

Service	N-1		N-2		N-3	
	Target	**No. attended to**	**Target**	**No. attended to**	**Target**	**No. attended to**
IPT						
ITNs						
De-worming						
2. Deliveries						
Deliveries by trained traditional birth attendants (TBAs)						
Deliveries by Classified Daily Employees (CDEs)						
Delivered by skilled provider (nurse-midwife or doctor)						
3. Maternal complications						
Post-partum haemorrhage						
Hypertensive diseases/eclampsia						
Abortions						
Prolonged labour						
Infections (direct)						
Vacuum extraction						
4. Family planning (FP)						
FP new acceptors						
Pill						
Injectables						
Implants						
Condoms						
IUDs						
Emergency contraception						
5. FP-re-attendance						
Pill						
Injectables						
Implants						
Condoms						
Intra uterine device (IUD)						
*Emergency contraception						
6. Youth friendly health services						
Family planning						
STIs						
HIV/AIDS						

Service	N-1		N-2		N-3	
	Target	No. attended to	Target	No. attended to	Target	No. attended to
Pregnancy						
6. Post abortion care (PAC)						
Manual vacuum aspiration (MVA)						
Dilatation and curettage						
7. Male circumcision						
8.**Other (specify)**						

* A woman is protected at second dose and fully protected at five5 doses.

3.2.3 Environmental Health

Table 3.2.3: Environmental Health

Indicator	Year N-3	Year N-2	Year N-1
Water			
% of population with access to safe water supply			
% of population using other sources such as shallow wells and streams			
Sanitation			
% of population using flush toilets			
% of population using pit latrines			
% of population using bushes/other			
Sources of energy			
% of population using electricity			
% of population using solar energy			
% of population using charcoal			
% of population using firewood			

Description of inspection of premises and foods, salt testing and water sampling activities.

3.2.4 HIV/AIDS Services

Table 3.2.4: HIV Services

Table 3.2.4a: Proportion of Clients Counselled for HIV Who Took an HIV Test

Facility	Number of counselling and testing clients								
	Year (n-1)			Year (n-2)			Year (n-3)		
	Counselled	Tested	%	Counselled	Tested	%	Counselled	Tested	%
Total									
Source: *HMIS*									

Table 3.2.4b: Proportion of Clients Taking an HIV Test

Facility	Year (n-1)			Year (n-2)			Year (n-3)		
	Tested	Positive	%	Tested	Positive	%	Tested	Positive	%
Total									
Source: *HMIS*									

Prevention of Mother-to-Child Transmission of HIV/AIDS

Table 3.2.4c: Proportion of Women Starting Antenatal Care Who Take an HIV Test at the Health Facility

Year (n-1)			Year (n-2)			Year (n-3)		
ANC 1st visit	Tested for HIV	% Tested	ANC 1st visit	Tested for HIV	% Tested	ANC 1st visit	Tested for HIV	% Tested

Table 3.2.4d: Proportion of Pregnant Women Testing HIV Positive at the Health Facility

Year (n-1)			Year (n-2)			Year (n-3)		
Tested for HIV	Tested Positive	% Positive	Tested for HIV	Tested positive	% Positive	Tested for HIV	Tested positive	% Positive

Table 3.2.4e: Proportion of Expected HIV-Exposed Babies Given ARV Prophylaxis at the Health Facility

Year (n-1)			Year (n-2)			Year (n-3)		
HIV exposed babies	No. given prophylaxis	% given prophylaxis	HIV exposed babies	No. given prophylaxis	% given prophylaxis	HIV exposed babies	No. given prophylaxis	% given prophylaxis

Table 3.2.4f: Cumulative Number of Patients Ever Enrolled on ART at the Health Facility

Year (n-1)			Year (n-2)			Year (n-3)		
Males	Females	Total	Males	Females	Total	Males	Females	Total

Table 3.2.4g: Proportion Ever Started on Therapy Against Target at the Health Facility

Year (n-1)			Year (n-2)			Year (n-3)		
Target	On therapy	%	Target	On therapy	%	Target	On therapy	%

Table 3.2.4h: Patients Currently on Therapy by Age and Sex at End of Each Year at the Health Facility

Year (n-1)					Year (n-2)					Year (n-3)				
0-14 years		15+ Years		Total	0-14 years		15+ Years		Total	0-14 years		15+ Years		Total
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M/F

3.2.5 Other Services

Health centres can include any information on programmes not listed above such as TB/HIV collaboration.

3.3 Health Facility Utilisation Rates

3.3.1 Health Facility Neighbourhood Health Committees

In this section, health centres provide information on other health facilities in the neighbourhood by ownership and type of services provided and the district hospital(s) to which they refer patients.

Table 3.3.2: Utilisation Rates

Year	Total first outpatient department (OPD) attendances	Total Population	Per Capita Attendances
Year $^{N-2}$			
Year $^{N-1}$			
Current Year			

3.4 Present Staffing

You are expected to fill in staffing levels as given in Table 3.4.1. Provide a short write-up on health worker availability.

Table 3.4.1: Staffing Levels by Category of Staff

Category of Staff	Establishment	Existing
Medical Officer		
Nursing Sister		
Clinical Officer		
Registered Midwife		
Registered Nurse		
Environmental Health Technologist/Technician		
Enrolled Midwife		
Enrolled Nurse		
Laboratory Technologist/Technician		
Laboratory Assistant		
Pharmacy Technologist/Technician		
Pharmacy Dispenser		
Dental Therapist		
Medical Imaging Assistant		
Clerical Officer		
Driver		
Classified Daily Employees		
Security Guard		
Total		

Table 3.4.2: Health Centre Daily Staff Contacts

Previous Year	Average Number of Professional Health Centre Staff	OPD/In Patient/Maternal and Child Health Contacts	Contacts per Staff Member per Day

Source: *Health Information Aggregation (HIA)1 and HIA2*

Table 3.4.5: Attrition by Staff Cadre and Cause for the Previous Year

Staff Category	Reason for Attrition							
	Retired	Resigned	Term of Contract	Dismissed	Deceased	Contract Expired	Transferred	TOTALS
Medical Officer								
Clinical Officer								
Registered Midwife								
Registered Nurse								
Environmental Health Technologist								
Enrolled Midwife								
Enrolled Nurse								
Laboratory Technician								
Laboratory Assistant								
Pharmacy Dispenser								
Dental Therapist								
Radiographer								
Physiotherapist								
Medical Imaging Assistant								

Staff Category	Reason for Attrition							
	Retired	Resigned	Term of Contract	Dismissed	Deceased	Contract Expired	Transferred	TOTALS
Clerical Officer								
Driver								
Classified Daily Employees								
Security Guard								
Total								

Source: Human Resource Data Base

3.5 Health Financing

Provide summary information about income and expenditure for the three year period

Table 3.5.1: Summary of Income and Expenditure by year

Income	Previous Year	Expenditure
Source of Funding		
Total		

Comment on critical items, such as fuel, drugs and allowances where expenditure is limited by ceilings. Describe any other potential resources for the health centre/post such as revolving funds, micro-projects, charitable institutions, etc.

3.6 Transport and Communications

- In Table 3.6.1, provide information on existing transport and status;
- In Table 3.6.2, provide details of fuel expenditure by level for a three year period; and
- In Table 3.6.3, provide the status of the communication system by institution.

Table 3.6.1: Inventory and Distribution of Current Transport (motor vehicles, motor bikes, bicycles)

Make	Type	Vehicle No.	Runner/ Non-Runner	Year Acquired	Amt Spent on Servicing to-date (K)	Where Based

Note: Comments should include information on vehicle status. Indicate those vehicles currently in the workshop.

Table 3.6.2: Health Centre/Post Fuel Expenditure for Last Year

Health Centre/Post Name	Cost Last Year

Table 3.6.3: Health Centre/Post Communication Support System

Name of Institution	Phones				Fax**		E-mail		Radios	
	Land*		Cell							
	No.	Status***	No.	Status	No.	Status	Available	Status	No.	Status

* Land refers to land phone line.

** Fax refers to fax lines.

*** Status refers to functional or non-functional; if number is '0' i.e. not available, status will be Not Applicable (NA).

3.7 Drugs and Medical Supplies

Write briefly about drugs and logistics/pharmaco-vigilance.

Also include the status of the infrastructure of the pharmacy storeroom and plans (if any) for improvement.

Table 3.7.1: Drugs and Supplies Expenditure

Description	Expected/Planned	Actual Received
Total number of contracts		
Drug kit		

3.8 Diagnostic Services

- In this table, provide information on laboratory services that have been undertaken during the year.
- Comment on each of the tests.

Table 3.8.1: Laboratory Services

Tests Carried Out	Number of Tests	
	Last year	Comments
Haematology		
Parasitology		
Malaria parasitology		
Microbiology		
HIV test		
TB sputum		
Others (specify)		

Table 3.8.2: Radiology (where this is relevant)

Type of Examination	Number of Tests	Comments
Medical examinations		
Routine investigations		
Others (specify)		

Note: *Comment on experience.*

3.9 Other Supportive Functions

- Describe any problems and special activities carried out in the previous year and experiences covering: pharmacy, catering services, laundry, mortuary, maintenance of buildings and equipment.

3.10 Quality of Services

- Provide a brief description of key findings from supervisory visits undertaken during the year to the community level.

Part 4: Main Plan

4.1 Progress on Previous Year's Plan

- Provide information on level of implementation and results achieved. Comment on reasons for failure to achieve expected results.
- Insert a summary of results of the strengths, weaknesses, opportunities, and threats (SWOT) analysis and enter results of the bottlenecks analysis in the table provided on the next page. For the main results of the local analysis of HMIS data and service delivery coverage, please enter this information into the tables provided in Part 3.1 (Health Status) of this planning guideline.
- Report on the main results of the performance assessment and self-assessment reports.
- This section together with sections two and three of the action plan outline form the basis for the selection of priority areas for the coming planning period.

Table 4.1: Summary of Bottleneck Analysis

Tracer Intervention: PMTCT: Service Delivery Model: Population Oriented Scheduled Services							
Coverage Determinants	**Indicators**	**Baseline Coverage (%)**	**Bottleneck yes/no**	**Possible Causes of Bottleneck**	**Proposed Operational Strategies/Solutions**	**Specific Activities to Be Undertaken**	**Expected Bottleneck Reduction**
Availability of essential commodities							
Availability of human resources							
Physical accessibility							
Initial utilization							
Timely continuous utilization							
Effective quality							

Note: Please refer to Annex 2 (Bottleneck Analysis) to complete the table. Please provide a summary of key bottlenecks to be addressed.

4.2 Logical Framework

You have now completed your situation analysis; please complete the logical framework template for each of your priorities. The purpose and the objectives are provided and all you are required to do is to provide targets against each of the indicators in the template illustrated below or additional indicators you may wish to add.

Unlike the traditional categorization of health care services, which is often disease-centred, has a vertical approach such as TB, HIV/AIDS or malaria programmes, this guide recommends that key results should be organised using the Marginal Budgeting for Bottlenecks (MBB) methodology around different service delivery mechanisms, namely family and community-based interventions, population-based schedulable services and individual-oriented clinical care services comprising health centre and first level referral clinical care services. This is because in the real world, health services are not delivered as a discreet set of disease specific activities, but as part of service delivery mechanisms with each delivery mechanism contributing towards addressing several health problems.

Four spreadsheets are provided to assist in the costing and budgeting for both districts and hospitals, namely the logframe, cost framework, consolidated spreadsheet and the activity sheet. The logframe has one purpose and two objectives, one for service delivery and the other for systems management. The only task for the planning team is to provide the targets in the spaces provided. The objectives correspond to yellow book programs. Each objective has a number of outputs corresponding to yellow book activities. The task for the planning team is to provide targets by year. In the column for Means of Verification, reports to be used in tracking the indicators should be listed.

Results Chain	Indicators	Means of Verification	Base Year	Target		
				2011	2012	2013
Purpose: To reduce disease incidence due to common illnesses	Under five mortality rate					
	Maternal mortality rates					
Objective 1: To provide affordable quality health care services to improve the health status in the catchment population	Malaria incidence					
	Malaria case fatality rate under 5					
	Measles incidence					
	Diarrhoea incidence in children					
Outputs						
1. 1 Individual clinical care services	% deliveries assisted by (aux-nurse) midwife or physician					
	% complicated pregnancy treated in quality emergency obstetric care (EOC) facility (basic-EONC or comprehensive-EONC)					
	% children with malaria receiving ACT from a skilled health worker					
	% eligible HIV+ adults receiving ART					
	% TB cases diagnosed and treated among all incidence TB cases					
1.2 Schedulable population services	ANC: % of pregnant women receiving 3 ANC visits including urine test					
	% HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce mother to					

Results Chain	Indicators	Means of Verification	Base Year	Target		
				2011	2012	2013
	child transmission					
	% children 12-23 months who received measles vaccination					
1.3 Community and family services	ITN: % of households with at least one ITN					
	% children with malaria receiving ACT at community level					
	IRS: % household sprayed					
Objective 2: To strengthen health service delivery structures to support the provision of quality health services						
Outputs						
2.1 Performance assessment	# active community health workers					
2.2 Supervision	% health facilities supervised monthly					
2.3 Administrative Support	% imprests retired					

A list of high impact interventions under each of the service delivery modes (family and community-based services, schedulable and outreach services, clinical services) is provided in *Annex 3*.

4.2 Cost Framework for Health Centre Level Activities

The list of broad activities against each of the outputs should be inserted in the table below. For the completion of this section, please refer to *Annex 3* for a list of high impact interventions. Clinical services should be divided between those provided at the health centre level and those provided at the first level referral care. The numbering in this sheet follows the pattern in the logframe. To complete the cost framework table, follow the steps below:

a. Organize activities from different programmes (malaria, HIV/AIDS, TB, IRH, child health, etc.) by service delivery mode and insert them in the relevant spaces in the cost framework. For the hospitals, activities are organized by service area (medicine, surgery, paediatrics, etc. and not service delivery mode.
b. In the space for timeframe, put an "X" in the quarter the activity will be implemented.
c. The column "GRZ" will house the cost of funding the activity using government funds. The grand total for all activities for this column should be equal to your indicative planning figure (IPF). The amount will come from the GRZ consolidated spreadsheet.
d. The column "Donor" will house the cost of implementing the activity using other sources including donors and locally generated revenue. The amount will come from the donor consolidated spreadsheet.
e. Put "yes" in the column "funded" if funding from the donor is confirmed and "no" if not.
f. The name of donor or user fee goes in the column called funder.

Table 4.3.1: Cost Framework for Health Centre Level Activities

Objective 1: Service delivery

	Timeframe				Cost by funder			Funded	Funder
	Q1	Q2	Q3	Q4	GRZ	Donor	Total		
Output 1.1 Health centre clinical services									
1.1.1 Activity									
1.1.2 Activity									
1.1.3 Activity									
Subtotal							-		
Output 1.2 Schedulable population services									
1.2.1 Activity									
1.2.2 Activity									
1.2.3 Activity									
Subtotal							-		
Output 1.3 Community and family services									
1.3.1 Activity									
1.3.2 Activity									
1.3.3 Activity									
Subtotal							-		
SUB TOTAL									

Objective 2 : Health systems strengthening

Output 2.1 Performance Assessment									
2.1.1 Activity									
2.1.2 Activity									
2.1.3 Activity									
Sub total									
Output 2.2 Supervision									
2.2.1 Activity									
2.2.2 Activity									
2.2.3 Activity									
Sub Total									
Output 2.3									

	Timeframe				Cost by funder			Funded	Funder
	Q1	Q2	Q3	Q4	GRZ	Donor	Total		
Administrative support									
2.3.1 Activity									
2.3.2 Activity									
2.3.3 Activity									
Sub Total									

SUB TOTAL

GRAND TOTAL

Information feeding into the cost framework is derived from the ***consolidated spreadsheets*** (*Annex 9*). There are two tables in the consolidated spreadsheet, the first being the revenue table and makes a provision to state expected income by funder and by month while the other table is the expenditure table. We advise that at least two tables be completed, one for GRZ and the other for donor. The third could aggregate the two tables. For the relevant objective output and activity, indicate the input costs in the provided spaces with activity total at the end of the row. The source of the cost information is the activity sheet (*see Annex 10*). To complete the activity sheet,

a. Indicate the relevant unit programme (objective) and output in the provided spaces. Provide a brief description or justification in the space provided.

b. Indicate the name of the activity in the space provided.

c. List all the inputs (daily subsistence allowance [DSA], fuel, stationery, etc.) required to implement the activity in column H labelled “G8”.

d. Insert the relevant input codes in the space provided from the chart of accounts provided in the sheet called “accounts”.

e. Indicate the quantity and unit cost for each input and calculate the cost by input.

f. Indicate using “yes/no” whether funding is internal and confirmed in the relevant columns.

g. Sum up input costs to get the total cost for the activity.

h. Go to the next activity and cost it in the same way.

4.4 Supportive Supervision

Describe planned schedule of visits to community level.

Table 4.4: Supportive Supervision

Technical Support Supervision			
Community	**Responsible Officer**	**When**	**Duration**
		Monthly	**No. Days**

Part 5: Budget

5.1 Distribution of Health Centre and Community Allocations

Table 5.1: Distribution of Health Centre and Community Allocations

Name of Neighbourhood Health Committee	Catchment Population	Budgetary Allocation for Following Year

5.2 Budgets for Transportation and Fuel

Information for completion of this table should be written on the budget spreadsheet attached to this handbook.

Table 5.2: Fuel Cost

Level/Activity	Expenditure Previous Year	Projected Cost Year 1
Health centre costs		
Community costs		
Total Costs		

Note: The total costs for these items for each level in the table above (DHO, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

5.3 Other Transport Costs

Table 5.3: Vehicle Hire Costs

Vehicle Hire	Cost
Total health centre	
Total community	
Total Costs	

Note: The total costs for these items for each level in the table above (DHO, first level hospitals) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

5.4 Repairs and Maintenance

Table 5.4: Repairs and Maintenance

	Repairs Required	Service Cost	Maintenance Cost	Total Cost
Total health centre				
Total community				
Total Costs				

Note: The total costs for these items for each level in the table above (DHO, first level hospitals and health centres) should be the same as the amounts entered on the Consolidated District Budget Spreadsheet.

Annex 1: Outline of Action Plans

Annex 1A: Health Centre

Table of Contents

Annexes

ANNEX 1B: Community Action Plan

Year: _____

Responsible Health Centre: _____

Name of Community _____

Total Community Population: _____

Community Action Plan

Key decisions and actions planned

Health problem	**Decision/activity**	**By when?**	**Persons/groups responsible**	**Remarks/any other comments**
Malaria	Example: 1.Organisisng community drama on malaria	End of March	NHC to work with drama group	Link and work with staff from health centre
	2.			
	3.			
Diarhoea	4.			
	5.			
	6.			
	7.			
HIV/AIDS	8.			
	9.			
	10.			

Date, Time and Location of next meeting……..

Name and Signature of Team Leader…….

Annex 2: Bottleneck Analysis

Annex 2A: Definitions

A bottleneck is an identified constraint to achieving goals and targets. The Marginal Budgeting for Bottlenecks or MBB, which uses the bottleneck analysis, is being rolled out in Zambia through nine pilot districts. This tool focuses on issues which prevent a health system from reaching its goals. The bottleneck analysis uses five implementation issues to identify issues at progressive levels. These are:

1. **Availability of essential commodities and human resources** – assessing the availability of critical health system inputs such as drugs, vaccines and supplies. This information is obtained from stock registers and facility surveys.
2. **Accessibility** – describing the physical access of clients to health services. Accessibility includes outreach services as well as physical and financial accessibility.
3. **Initial utilization** – describing the first use of a multi-contact service, for example, first ANC contact or BCG immunization. Initial utilization indicates the members of the target population actually using the service(s).
4. **Timely, continuous utilization** – indicating whether patients get the full treatment. This aspect documents the continuity of care and compliance.
5. **Effective quality** – explaining the quality of care measured by assessing the skills of the health workers. Effective quality means that potential clients are receiving quality care.

These determinants are sequential. Bottlenecks are identified by examining the gaps among the five determinants and finding the weakest link in the service delivery chain. For example, the figures below reveal that the bottlenecks in EPI coverage (seen as drops in coverage) are multiple:

ii. Availability of EPI is low (30%) at district level with frequent stock outs of basic vaccines;

iii. Use at household level is insufficient, with mothers not bringing their children in for vaccination (20%);

iv. Besides this the quality is poor with only 2% of children fully vaccinated at 11 months.

The key here is to reduce stock outs and address the reasons why mothers are not using the immunization services.

Since the bottlenecks affecting scaling-up interventions at a given level of service delivery are common, it is prudent to choose a representative intervention to act as a tracer for each service delivery mode and do an analysis for the five implementation issues (**availability** of essential commodities and human resources; **accessibility**; initial **utilization;** timely, **continuous** utilization; and effective **quality)** with regard to existence of bottlenecks, sources of bottlenecks, solutions to remove bottlenecks, specific actions to be taken and the expected bottleneck reduction measured by specific indicators as in the example below.

Annex 2B: Example of Bottleneck Analysis (EPI)

Coverage determinants	Indicators	Baseline coverage (%)	Bottleneck yes/no	Possible causes of bottleneck	Proposed operational strategies/solutions	Specific activities to be done	Expected bottleneck reduction
Availability of essential commodities	% HC with sufficient stocks of vaccines and injection material	90% (source: PETS)	Yes	Forecasting and management skills, Break down of cold chain, Mal distribution of logistics and vaccines	Improve forecasting skills Improve Cold chain management Mid level managers training	Train mid level EPI managers (Road Map: train 144 district staff) Train staff in cold chain management Train staff in maintenance of the cold chain equipment (EPI technicians) Train staff in logistics and vaccine management (specify numbers to be trained)	Increase from 90 to 95% by 2010 (50% bottleneck reduction)
Availability of human resources	Availability of , nurse, EHT& CO in relation to need	50%	Yes	Insufficient numbers are trained each year, Lack of incentives to retain skilled staff	Scale up training of the core health workers (CO, Nurses, EHT) both pre and in-service training, Accelerate the scale up the retention scheme, Re introduce training of family health nurses	As per the HR plan – curricula are currently being developed Train core health workers (CO, Nurses, EHT) Accelerate the scale up the retention scheme Re introduce training of family health nurses	55% by 2010
Physical accessibility	% Neighbourhood Health Committees regularly receiving outreach for EPIplus	85%	Yes		Outreach Construction of health posts		Increase access from 85% to 90% by 2010 (30% gap reduction) Increase access to 95% by 2015 (70% gap reduction)
Initial utilization	% children 12-23 months who received BCG	97% (JRF)	No				
Timely continuous utilization	% children 12-23 months who received Pentavalent 3	92% (JRF)	No				

Coverage determinants	Indicators	Baseline coverage (%)	Bottleneck yes/no	Possible causes of bottleneck	Proposed operational strategies/solutions	Specific activities to be done	Expected bottleneck reduction
Effective quality	% children 12-23 months fully immunized	77%	Yes	1. Poor communication between health worker and care giver 2. Limited timely access to immunization services 3. Hard to reach populations	Strengthen the RED/C strategy	Promote key messages between health worker and care giver Plan for regular out reach Targeted key messages for the hard to convince populations	80% by 2010

Annex 3: High Impact Interventions

Recent studies and subsequent publications have reconfirmed that around two-thirds of maternal and child mortality can be prevented through existing and proven health and nutrition interventions. Focusing on these activities will mean using the scarce resources available to get the most results. Below is a list of selected evidence based, high impact interventions, organized into community, primary and referral level activities.

Services Delivered by the Community for the Community	**Primary Health Care and Outreach Activities**	**Clinical Care**
ITNs for under-five children/pregnant women	Family planning	Skilled delivery care
Supply of safe drinking water	Iron folate	Basic emergency obstetric care (basic EOC)
Latrines	ANC	Management of neonatal infections at primary health care level
Hand washing	Calcium supplementation in pregnancy	Antibiotics
Indoor residual spraying (IRS)	Tetanus immunization	Vitamin A - treatment for measles
Clean delivery and cord care	Deworming in pregnancy	Zinc for diarrhoea management
Breastfeeding	Prevention and treatment of iron deficiency anaemia in pregnancy	Appropriate treatment for malaria (ACT)
Complementary and supplementary feeding	Intermittent Presumptive Treatment (IPT) for pregnant women	Management of complicated malaria (second line drug)
Care for orphans	Balanced protein energy supplements for pregnant women	Antibiotics for opportunistic infections, under five pneumonia, diarrhoea and enteric fever
Oral rehydration therapy (ORT)	PMTCT	Male circumcision
Zinc	Condom use	ART
Vitamin A	Cotrimoxazole prophylaxis for HIV + mothers, adults, children of HIV + mothers	DOTS for TB
Malaria treatment of children	Immunizations	Detection and management of (pre) eclampsia (Mg sulphate)
Antibiotics at community level	Post-partum vitamin A supplementation	Management of neonatal infections at primary referral level
	Vitamin A supplementation	Comprehensive emergency obstetric care (comprehensive-EOC)
		Clinical management of neonatal jaundice
		Universal emergency neonatal care
		Management of first line ART failures
		Management of TB moderate toxicities

Annex 4: Planning Guidance for HIV/AIDS

Please refer to this guide when planning for HIV/AIDS services to select appropriate interventions.

Service Delivery Area	Area of Focus (Activity)	Key Indicator
1. Sexually transmitted infections (STIs), diagnosis and treatment	►Screening and treatment of STIs using the Syndromic Management approach	►Number of health workers (public and private) trained in Syndromic Management of STIs
	► Drugs, reagents and medical supplies	►% of patients with STIs at health facilities diagnosed, treated and counselled according to national guidelines
2. Information, education/behaviour change communication (BCC)	►Appropriate information and BCC materials and messages	►% of young people aged 15-19, who correctly identify consistent use of condoms to prevent HIV transmission
3. Condom promotion	►Promote accurate and consistent use of male and female condoms to all sexually active individuals	►% of young people aged 15-19, who correctly identify consistent use of condoms as a way of preventing sexual transmission of HIV
4. Counselling, testing and care	►Training of counsellors	►Number of clients counselled and tested for HIV at VCT sites ►Number of VCT sites established
	►Establishment of voluntary counselling and testing (VCT) sites	
	►Availability of HIV test kits (applicable to centres conducting tests)	
	►Infrastructure and equipment	
	►Referral systems	
5. PMTCT of HIV	►Provide information to the public on PMTCT	►Number of sites providing PMTCT ►Number of HIV positive mothers receiving adequate prophylaxis (ARVs)
	►Availability of HIV/STI screening and treatment facilities	
	►Establish or strengthen PMTCT facilities	
	►Facilitate access to ARVs for all mothers meeting treatment criteria	
	►Provide information to mothers on breast feeding options	
7. Palliative care	►Supportive projects ►Distribution of medicine kits	►Number of chronically ill persons enrolled in community home based care and support projects
8. Anti-retroviral Therapy (ART)	►ART scale-up as per national scale-up plan	►Number of patients receiving ARVs ►% of ART centres having fewer than 14 days ARV stock-out per quarter
	►Training health care providers	
	►Drugs (ARVs) (applicable to centres prescribing ARVs)	
	►HIV test kits	
	►Training in monitoring of efficacy and toxicity of ARVs	
	►Adherence support groups	
	►Post-exposure prophylaxis (PEP)	
	►Training in ART information system (reporting)	

Service Delivery Area	Area of Focus (Activity)	Key Indicator
	►BCC in positive living	
	►Referral	
9. TB and HIV (Co-infection)	►Training health workers and non-health workers	►Cure rate of 85% ►Number of persons accessing first line anti-TB drugs
	►Drugs (STI drugs, ARVs, opportunistic infection drugs, anti-TB drugs)	
	►VCT, STI screening	
	►Prophylaxis	
10. Laboratory	►Trained laboratory technicians (for centres with laboratories)	►Number of health facilities with trained laboratory technicians
	►Reagents and equipment	
11. HIV and nutrition	►Nutrition interventions at all levels	►Number of persons living with HIV/AIDS receiving information on nutrition ►Number of people with HIV and AIDS receiving micronutrients
12. Management of opportunistic infections (OIs)	►Strengthen skills in management of OIs	
	►OI drugs	
13. Work place programmes (absenteeism, loss of productive health workers, high funeral costs and compromised performance)	►Counselling, testing and care for health workers	
	►Train peer counsellors at work place	
	►Referral system	
	►ART schemes	
14. Monitoring and evaluation	►District data management	►Number reports submitted timely

Annex 5: Format for Reporting Action Plan Implementation

Name of Health Centre……Quarter……. Year…….

Programme	Planned Activities	Status	Comment	Expenditure in Kwacha		Challenges / Constraints
				Budget	Actual	
Community level						
Schedulable services						
Clinical care services						

Note: Use this format to generate the Annual Report

Annex 6: Drug and Medical Supplies Ledger Cards

At the time of the meeting between the health centres/health posts, the hospitals, NGOs and the DHO to prepare the health centre action plans for the next MTEF, the DHO will notify each health centre and health post of its projected allocation of money for drugs and medical supplies. The health centre should record these amounts in the "balance remaining" column on the stock ledger cards as follows:

Annex 6A: Health Centre - Health Post Drug Allocation Stock Ledger Card

Date	Drugs Received	Value of Drugs Received	Balance Remaining	Expiry Date	Remarks

Annex 6B: Health Centre/Health Post Supplies Allocation Stock Ledger Card

Date	Supplies Received	Value of Supplies Received	Balance Remaining	Remarks

Each time the health centre or health post receives a delivery of drugs and medical supplies from the DHO, staff should enter what has been received onto the appropriate stock ledger card together with the date it is received. The value of what it receives will be given to them by the DHO at the time of delivery in the form of a "delivery note".

Each quarter, the DHO will prepare a statement for each health centre and health post of the value of the drugs and medical supplies that have been provided. Each health centre and health post should check this statement against its own stock ledger cards to confirm the accuracy of the statement. Once checked and confirmed, the health centre/health post should present the statements to the Neighbourhood Health Committee (NHC) or HCC at the next meeting. Each statement should be signed by the chairperson of the Committee (or by the chairperson of the Finance Sub-Committee).

Drug and Medical Supplies Stock Ledger Cards (page 2)

Although rural health centres and health posts at present do not have to budget for their drug kits, this may not always be the case. It is, therefore, important that each health centre and health post begins to track the value of the kits that they receive and the drugs they dispense. In order to do this, each rural health centre and health post should maintain a simple stock ledger card which records the number and the value of the drug kits received, as shown on the sample card below.

Annex 6c: Health Centre/Health Post Drug Kit Stock Ledger Card

Date	Number of Kits Received	Value of Kits Received

Each time the health centre or health post receives a delivery of drug kits from the DHO, staff should enter what has been received onto the appropriate stock ledger card together with the date it is received. The value of what it receives will be given to them by the DHO at the time of delivery in the form of a "delivery note".

Annex 7: Stock Control Cards

Each health centre and health post should maintain a stock control card for every drug and medical supply item that is held at the facility. As items are received at the health centre/health post, the appropriate stock control cards should be updated by entering the date and the amounts received. As items are issued from the stock, the stock control card should again be updated by entering the date the item was issued and the quantity issued.

Health Centre/Health Post Stock Control Card

Item Description:		
Date	**Received**	**Quantity Issued**

Annex 8: Health Centre Income and Expenditure Record

Each health centre should prepare a monthly report on the fees it has collected and its expenditure from its imprest and submit this to the DHO with all the necessary receipts attached. The report should contain the following information:

Health Centre Income and Expenditure Report

Name of Health Centre: .....

Month: .....

Income		**Expenditure**	
Source	**Amount**	**Item**	**Amount**
Imprest received		Stationery	
Medical fees		Cleaning materials	
Medical imaging fees		Other supplies	
Laboratory fees		Utility costs	
Dental fees		Telephone	
Drug fees		Petrol	
Pre-payment		Paraffin	
Payment in kind		Personnel salaries	
Donor contributions:		Part-time staff	
		Housing costs	
		Maintenance	
		Drugs	
Other (specify):		Food	
		Other (specify):	
Total Income			

Annex 9: Consolidated Budget Spreadsheet

Health Centre:_____ **Health Centre In-Charge:_____** **PERIOD: JAN - DEC Year _____**

(AMOUNTS= x 1,000)

INCOME		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	TOTALS
	GRZ													
Grant Funds	*Basket*													
Local Revenue														
Local Donors														
Sub-total														
Medical Stores Limited (MSL) Drugs														
Personal Emoluments (PEs)														
Capital Investment Plan (CIP) Funds														
TOTAL INCOME														

Expenditure by Programme and Cost Item

Objective 1: Service Delivery

Output	Activities	Office costs			Requisites			Travel			Building repair and maintenance costs				Services		Training			Machinery and vehicle costs			Non-financial assets			TOTAL
		Office materials	Tel	Other (specify)	Medical supplies	Drugs	Food supplies	Daily subsistence allowance	Petrol, oil, etc.	Accommodation charges	Office furniture & fitting	Water	Elec	Building maintenance	Accommodation	Conferences and workshops	Training allowances	Training and education charges	Workshops and conferences	Spare parts	Insurance	Petrol, oil, etc	Medical equip	Non-med equip	Vehicles	
Health centre clinical care																										
	Sub Total																									
Scheduled/outreach services																										
	Sub Total																									
	Sub Total																									
Programme Total																										

54

Objective 2: Health Systems Strengthening

Output	Activities	Office costs			Requisites			Travel			Building repair and maintenance costs				Services		Training			Machinery and vehicle costs			Non financial assets			TOTAL
		Office materials	Tel	Other (specify)	Medical supplies	Drugs	Food supplies	Daily subsistence	Petrol, oil, etc	Accommodation charges	Office furniture and fitting	Water	Elec	Building maintenance	Accommodation	Conferences and workshops	Training allowances	Training and education charges	Workshops and conferences	Spare parts	Insurance	Petrol, oil, etc	Medical equip	Non-med equip	Vehicles	
Performance assessment	**1.1.1**																									0
	Sub Total																									
Supervision																										
	Sub Total																									
Administration																										
	Sub Total																									
Programme Total																										
Grand Total																										

Annex 10: Activity Sheet

B. Unit Kasama Urban Clinic

C. Program Service delivery

D. Output Schedulable services

E. Description	Essential newborn care which is usually facility based will be harmonized with the home based care of the newborn. An assessment of the impact made by the trained frontline workers in essential newborn care will be done.
F. Activity 1	Follow up visits to health centres with trained personnel in essential newborn care

G. Inputs

G1	G2	G3	G4	G5	G6	G7	G8	G9	G10	G11	G12	G13	G14
Funding Source: (e.g, GRZ, EU)	Funding Type (GRZ, Loan or Grant)	Account type code	Subhead code	Item code	Sub item code	Subsub item code	Subsub item name	Unit Cost	Quantity	No. of days	Total	Internal Funding (Yes/No)	Funds Available (Yes/No)
GRZ	GRZ	2	2	8	1	10	DSA	295,000	20	5	29,500,000	Yes	Yes
GRZ	GRZ	2	2	8	1	40	Fuel	1,725	5,000	2	17,250,000	Yes	Yes
GRZ	GRZ	2	2	8	1	30	Lunch	50,000	30	5	7,500,000	Yes	Yes
Activity Total											54,250,000		

ANNEX 10B: Guidelines for Engagement of Communities in Health Planning

Purpose
The purpose for this guide is to provide a step-by-step process for the health centre staff on **"how to engage communities"** throughout the planning process. Health centre staff have the responsibility to guide communities to come up with activities that are based on health problems in their environments.

The suggested activities should be in line with the overall Ministry of Health (MOH) goals and objectives which are derived from the National Health Strategic Plan (NHSP). Prior to the annual district planning launch, the health centre should start engaging their respective communities through their monthly Health Centre Advisory Committee (HCAC) meetings. The HCAC members who are representatives of the Neighbourhood Health Committee (NHCs) should meet their NHCs and community members to brief them on the meeting with HCAC and get their input on health problems. This process is aimed at strengthening effective engagement of communities in planning. The role of the district health office is to ensure that all health centres are undertaking this activity with their communities.

STEP 1: Getting started

The following things should be put into consideration:

- Put together a well-represented HCAC team which will be responsible for the overall planning process. The health centre staff should facilitate the selection of a team which will be easy to orient and can facilitate the planning steps in the community.
- The health centre should also incorporate other key community groups such as,
    - Safe Motherhood Advisory Groups(SMAGs),
    - Child health supporters,
    - Malaria agents
    - Youth support groups,
    - Civic leaders,
    - Traditional leaders, and
    - Other community-based organizations

The purpose of this stage is for the health centre staff to ensure that all key intervention areas are well represented and that decisions reached have been agreed by those representing various groups.

STEP 2: Orientation of HCACs to planning

- The health centre staff will hold a meeting to orient the HCAC on the planning process.
- The health centre staff should prepare the following information for the meeting which will be shared with the HCAC.
    - HMIS information which will show how they have performed during the past year.
    - Findings from supervisory visits that the health centre will have made during the year on community groups.

- Existing partners and their areas of support and where they are operating from.
- Strategic focus for the MOH.
- Share the previous year's plan, achievements, constraints and funding information.

STEP 3: HCAC meeting with community members

The HCAC members should go back to their communities and call for a community meeting with the help of community leaders, to brief them on the meeting held with the health centre.

STEP 4: Conducting needs assessment

The community should conduct a needs assessment using any of the following tools: mind mapping, transact walk and community mapping or an environmental risk assessment. The health problems identified in the community will be listed by the note taker one by one on a card, sticking each card on the wall or placing them on the ground for all to see.

STEP 5: Identifying root causes

Facilitator(s) from the health centre will lead the community to conduct a problem analysis in order to identify the actual root causes to the problems. They can use the problem tree method of analysis. Example is as follows:

Annex 11: Example of a Problem Tree

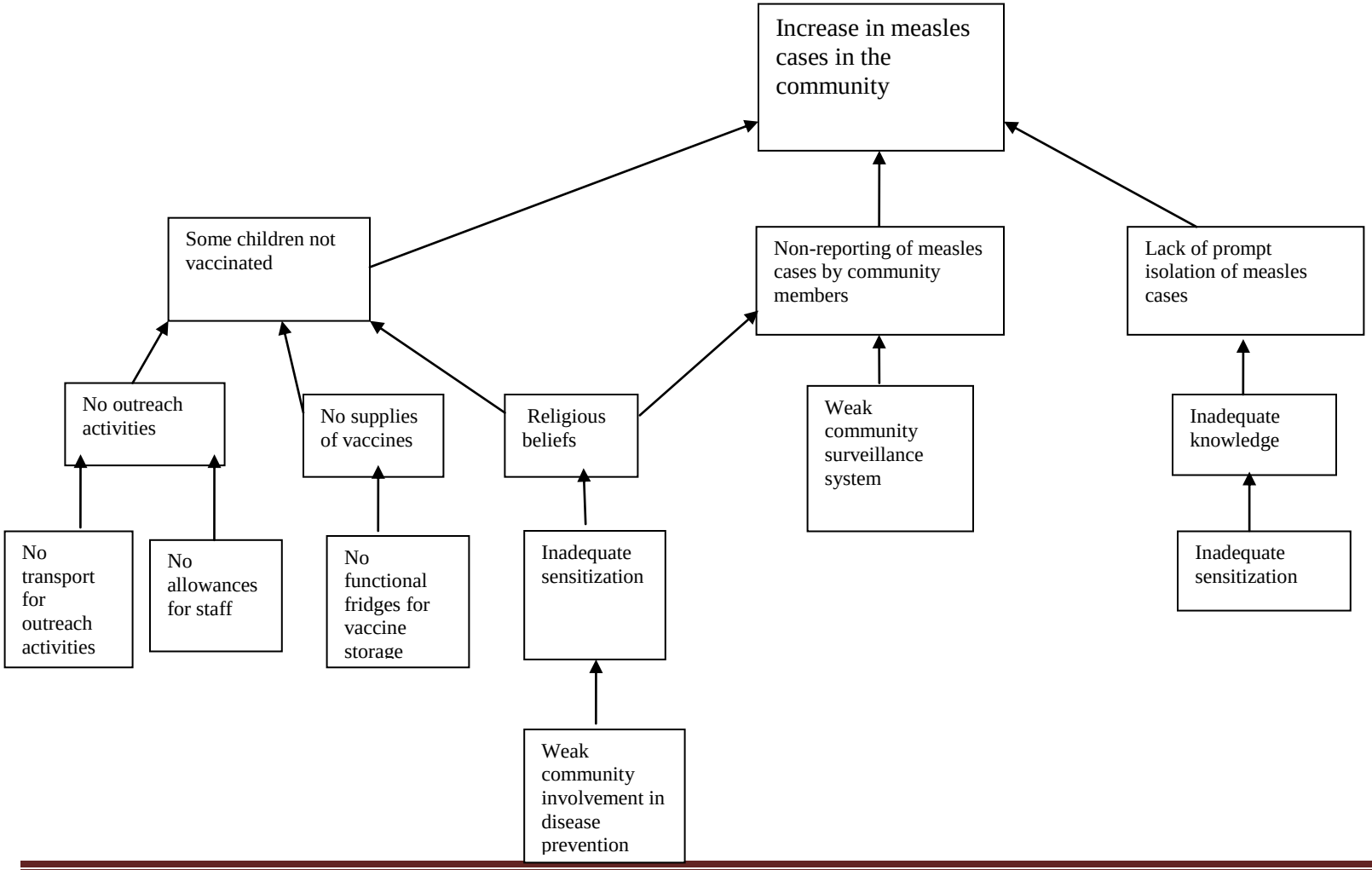


Table: 10.1 Identification of root causes and possible solutions

Root causes	Solutions to be provided by community	Solutions to be provided by other partners
No transport for outreach services	Communities to mobilize local transport system, e.g., bicycles	
No allowances for staff outreaches		DHO to ensure staff allowances are paid regularly
No functional fridges for vaccine storage		DHO to ensure vaccine fridges are functional
Weak community involvement in disease prevention programs		
Weak community surveillance system		
Inadequate sensitization of the community on infectious diseases		

Note: Solutions to be used to develop activities in the community action planning.

Once the community has identified their health problems and the root causes, the facilitators should now help the community to prioritize the causes using a simple scoring method, and identify solutions to address identified gaps. The resources are scarce and may not be adequate to address all the identified health problems, hence the need to prioritize.

Example of Scoring Matrix

Table: 10.2 Under 5 children

List of identified health problems in the community	Criteria for scoring most serious and common health problems.			List in order of priority problems (*The highest score is the priority*)
	Cause lots of illnesses	Cause lots of deaths	Total counters	
Malaria	☺ ☺ ☺ ☺	☺ ☺	6	Malaria (3)
Diarrhoea	☺ ☺ ☺	☺ ☺ ☺ ☺	7	Diarrhoea (2)
Ringworm	☺ ☺		2	Ringworm (4)
Malnutrition	☺ ☺ ☺ ☺	☺ ☺ ☺ ☺	8	Malnutrition (1)

Table: 10.3 Adolescents

List of identified health problems in the community	Criteria for scoring most serious and common health problems			List in order of priority problems (*The highest score is the priority*)
	Cause lots of illnesses	Cause lots of deaths	Total counters	
Malaria	☺ ☺ ☺ ☺	☺ ☺	6	Malaria (4)
Diarrhoea	☺ ☺ ☺	☺ ☺ ☺ ☺	7	Diarrhoea (3)
Ringworm	☺ ☺		2	Ringworm (5)
Pregnancy related complications	☺ ☺ ☺ ☺ ☺ ☺ ☺	☺ ☺ ☺ ☺ ☺ ☺ ☺	14	Pregnancy related complications (1)
STI	☺ ☺ ☺ ☺	☺ ☺ ☺ ☺	8	STI (2)
Upper respiratory tract infections (URTI)	☺		1	URTI (6)

Table: 10.4 Pregnant women

List of identified health problems in the community	Criteria for scoring most serious and common health problems			List in order of priority problems (*The highest score is the priority*)
	Cause lots of illnesses	Cause lots of deaths	Total counters	
Malaria	☺ ☺ ☺ ☺	☺ ☺	6	Malaria (4)
Diarrhoea	☺ ☺ ☺	☺ ☺ ☺ ☺	7	Diarrhoea (3)
Malnutrition	☺ ☺		2	Malnutrition (5)
Pregnancy related complications	☺ ☺ ☺ ☺ ☺ ☺ ☺	☺ ☺ ☺ ☺ ☺ ☺ ☺	14	Pregnancy related complications (1)
Anaemia	☺ ☺ ☺ ☺	☺ ☺ ☺ ☺	8	Anaemia(2)
STIs	☺		1	STI (6)

STEP 6: Identifying activities and agreeing on support

The facilitator(s) should then lead the meeting to identify which activities will be supported by the health centre budget and other activities which will still be part of the consolidated district health plan but without a budget. Once this process has been completed, the health centre and community members are now ready to budget for the activities. Communities can source funding for the unsupported activities.

Annex 12: Mind Mapping

Introduction
Mind mapping is one of the tools that can be used to collect community-based information on health problems affecting the communities. The tool allows the facilitator and community to conduct brainstorming sessions in a systematic approach to resolving or presenting ideas or tasks. The Mind Map helps individuals or a group(s) of people on how best to learn, create fresh ideas and foster innovation.

Purpose
Mind Mapping is a tool used for investigating, planning, creating and presenting problem solving. It helps in creative and engaged learning of groups; it organizes thinking and increases memory by summarizing words or notes in to pictures. Therefore, Mind Mapping is a tool that provides visual maps of ideas which take a central idea and then spans out from this in a circular shape.

How to do Mind Mapping with communities
Mind Mapping is done by drawing branches from a central idea by simply adding key words, colours and images to the branches.

STEPS

1. Decide on the topic of your Mind Map. The topic will help you form a central idea, e.g., "We are going to plan to improve immunization coverage."

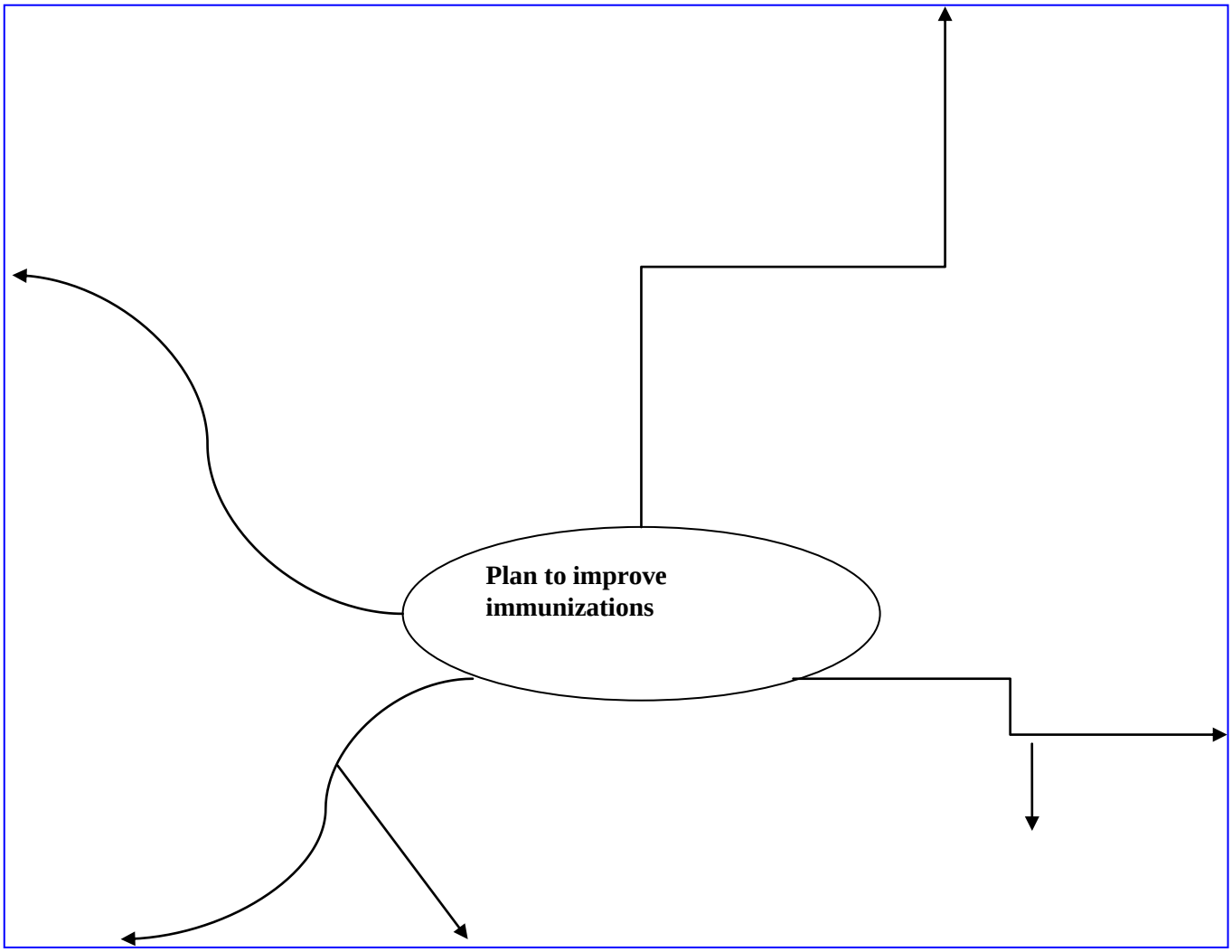
2. Take a sheet of plain paper and some coloured pencils or markers and then turn the sheet of plain paper to the landscape position.

3. Draw an image in the centre that represents your topic, e.g., if your topic is to plan to increase immunization coverage, you may put an image of a baby being vaccinated.

4. By putting the image in the centre of the landscaped sheet of paper, you allow and aid the thought process of an individual or group (s) to spread and increase creativity and inspiration to come up with more ideas.

5. Make thick lines (curvy, straight, etc.) from the central idea and put suggestions along the line.

6. You can add branches from the central idea which can be illustrated by further pictures at the extreme.



Environmental health risk assessment

The ultimate goal of an environmental health risk assessment is to protect human health and the environment by providing the community with information that can be used to minimize risks posed by environmental agents or factors. A risk assessment can be used to predict the likelihood of many unwanted occurrences of disease, household injuries and the presence of infections. A modern health risk assessment is a growing discipline for improving the health of the people. By identifying hazards in the environment and the likelihood of the hazard causing harm, a level of risk is anticipated or determined to an individual or community.

A risk assessment can further be used by communities to gather data for purposes of prioritizing (use scoring matrix) the main risk factors and minimize the **effects** of risk factors present in the community.

Communities may identify risks arising from natural catastrophes such as floods that adversely impact on health. The concept has a strong link to high impact interventions.

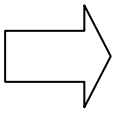
The assessment (identification) can be done during a transect walk and later the community may or can use the Mind Mapping to discuss and create ideas on how to eliminate/reduce the risks and/or list the risks present in the communities.

A risk assessment therefore evaluates and usually quantifies the risks to human health and the environment posed by contaminants, lead-based paint, asbestos-containing building materials, inadequate sanitation, poor water sources, uncontrolled dogs, leaking sewer pipes, presence of vectors (rodents/insects), proximity to agriculture, industries and transportation, hazardous materials, food vendors, water quality, solid waste disposal practices, public safety (foot traffic/foot paths/side-walks), uncollected solid waste, collapsed VIP latrines, and blocked sewers.

STEPS

1. Identifying the contaminant or hazard.
2. Identifying the health effects associated with these contaminants.
3. Identifying how exposure may occur.
4. The three determines the magnitude.

Is there a source of contamination?	**Where is the contamination? Can it move?**	**Can people come in contact with the contamination/ infection?**	**Can the contamination be absorbed in the body?**
Source	Media	Exposure	Absorption
Spillage Use of toilet Preparation of food	Ground water Hands Food Land	Drinking the water Eating food Handling food Sleeping without ITN Chemical storage –paraffin Mosquito bite	Ingestion



Potential Risk

Annex 13: Standard Equipment List

ANNEX 13A: Standard Equipment for Health Post

Items	Method to calculate adequate quantity for health post (HP) with qualified staff (Clinical Officers, nurse or EHT)	Priority Ranking
Screening Room and Pre- and Postnatal Room		
Ambu bag for adults (resuscitator)	1 per HP	5
Ambu bag for children (resuscitator)	1 per HP	5
Arm circumference tape	1 per HP	4
Autoclave, electrical, small (if electricity available)	1 per HP	5
Autoclave, non-electrical, 39 litres (if no electricity)	1 per HP	5
Bedside screen	2 per HP	4
Sphygmomanometer (BP machine, adult)	1 per HP	5
Chair for consulting staff	1 per HP	5
Chair for patient	2 per HP	5
Desk for consulting staff	1 per HP	5
Drainage set	1 per HP	5
Dressing set	1 per HP	5
Dressing tray	1 per HP	5
Ear syringe	1 per HP	3
Equipment cabinet	1 per HP	3
Examination couch without leg holders	1 per HP	5
Examination light	1 at HP with electricity or suitable solar energy supply	4
Gallipots, large	2 in addition to sets	3
Gallipots, medium	2 in addition to sets	5
Hospital bed, health centre/health post model	1 for observation	5
Indicator, TST control spot, pack 300	1 per HP	5
Instrument tray, large	1 per HP	3
Instrument tray, medium	1 per HP	5
Instrument trolley	1 per HP	2
Kidney dish, large	1 in addition to sets	3

Items	Method to calculate adequate quantity for health post (HP) with qualified staff (Clinical Officers, nurse or EHT)	Priority Ranking
Kidney dish, medium	1 in addition to sets	5
Otoscope set in case	1 per HP	4
Sterilising drum, small	1 per HP	5
Stethoscope	1 per HP	5
Stove, kerosene, single burner	1 per HP	5
Stretcher, folding type	1 per HP	3
Suction pump, foot operated	1 per HP	5
Suturing set	1 per HP	5
Thermometer jar	1 per HP	3
Thermometer, digital	1 per HP	5
Timer, 60 min	1 per HP	5
Torch, medical, pen-sized	1 per HP	5
Vaginal speculum, large	2 per HP	4
Vaginal speculum, medium	2 per HP	5
Vaginal speculum, small	2 per HP	3
Waste bin with lid	3 per HP	3
Weighing scale, adult	1 per HP	5
Weighing scale, hanging, children	1 per HP	5
Weighing trousers	5 per salter scales (because they are sold this way)	5
Equipment Specifically for Delivery Room		
Bed pan	2 per HP	3
Bowl, lotion, large	1 per HP	4
Bowl, lotion, medium	2 per HP	5
Bowl, lotion, small	1 per HP	3
Bucket, stainless steel	1 per HP	4
Delivery bed	2 per HP	5
Drip stand	1 per HP	5
Footstool, one-step	2 per HP	4
Stethoscope, foetal, Pinard	1 per HP	5
Vaginal delivery/episiotomy set	2 per HP	5
Wall clock	1 per HP	5
Weighing scale, infant, beam type	1 per HP	5
Equipment Specifically for Ante/Postnatal Room		

Items	Method to calculate adequate quantity for health post (HP) with qualified staff (Clinical Officers, nurse or EHT)	Priority Ranking
Bedside cabinet (locker), health centre/health post model	1 per bed	3
ITN	1 per bed	3
Hospital bed, health centre/health post model, with mattress	2 for ante/postnatal room	5
Infant cot bed net, treated	1 per cot	3
Infant cot with mattress	1 per postnatal bed	3
Pharmacy		
20 ml medicine cup	1 per HP	3
Lockable drug cabinet	1 per HP	4
Refrigerator for vaccines	1 per HP	5
Vaccine carrier	1 per HP	5
Vaccine cold box	1 per HP	5
Laboratory equipment		
Glucometer	1 per HP	5
Haemoglobinmeter	1 per HP	5
Rapid Diagnostic Test kit for malaria		5
RPR shaker, electric if possible	1 per HP	5
Environmental Health Equipment		
Bucket for mixing chemicals	3 per HP	5
Food and water sample box	1 per HP	5
Lovibond Comparator	1 per HP	5
Measuring jar	3 per HP	5
Meat inspection kit	1 per HP	5
Personal Protective Equipment	1 per staff involved in environmental health activities	5
Rodent control apparatus	1 per HP	3
Squirt gun	1 per HP	5
Tape measure	1 per HP	5
Vector control sprayer	1 per HP	5
Water level meter	1 per HP	5
Miscellaneous Equipment		
Camping equipment set	1 per HP	5
Fire extinguisher	1 per HP	2
Health Post solar power supply system for light, cold chain and laboratory	1 per HP	5

Items	Method to calculate adequate quantity for health post (HP) with qualified staff (Clinical Officers, nurse or EHT)	Priority Ranking
Health Post/Health Centre maintenance kit	1 per HP	2
Hurricane lamp	1 per HP	1

ANNEX 13B: Standard Equipment for Health Centre

Items	Method to Calculate Adequate Quantity	Priority rating
Equipment and Furniture for OPD and Wards, including Maternity		
Ambu bag for adults (resuscitator)	2 per health centres: 1 for OPD/wards + 1 for maternity ward	5
Ambu bag for children (resuscitator)	1 per health centres	5
Autoclave, electrical, small	1 at OPD and 1 for wards	5
Autoclave, non-electrical, 39 litres	1 per health centres	5
Bed pan	1 per 4 beds	4
Bedside cabinet (locker), health centre/health post model	1 per hospital bed	3
Bedside screen	1 per consulting room and 1 per 4 beds in wards	2
Bowl, lotion, large	2 per health centres	4
Bowl, lotion, medium	3 per health centres	5
Bowl, lotion, small	2 per health centres	3
BP machine, adult	1 per qualified staff, minimum 2	5
Bucket, stainless steel	1 per delivery bed	4
Chair for consulting staff	1 per consulting room, 1 per ward	5
Chair for patient	2 per consulting room + 1 per beds in wards	5
Delivery bed	1 per delivery room	5
Desk for consulting staff	1 per consulting room, 1 per ward	5
Drainage set	1 per health centres	5
Dressing set	1 for OPD + 1 for wards	5
Dressing tray, medium	1 for OPD + 1 for wards	5
Drip stand	1 per 4 beds, including couches	5
Ear syringe	1 per health centre	3
Equipment cabinet	2 per health centre	3
Examination couch without leg holders	1 per consulting room	5
Examination couch, gynaecological	1 per health centre	5
Examination light	1 per consulting room at HC with electricity or suitable solar energy supply	2
Foot stool, one-step	1 per delivery bed	4
Gallipots, large	2 per health centres as part of sets + 1 as loose item	3
Gallipots, medium	2 per health centres as part of sets + 1 as loose item	5
Hospital bed back rest	1 per 4 beds	2 or 3
ITN	1 per hospital bed	3
Hospital bed, health centre/health post model, with mattress	no planning guidelines available	5
Indicator, TST control spot, pac-300	Consumable	5
Infant cot bed net, treated	1 per infant cot	3
Infant cot with mattress	1 per post-natal bed	3
Infection prevention trolley	?	?
Instrument tray, large	1 per treatment room	3
Instrument tray, medium	1 per treatment room	5
Kidney dish, large	1 kidney dish per health centre as part of sets + 1 as a loose item	3
Kidney dish, medium	1 kidney dish per health centre as	5

Items	Method to Calculate Adequate Quantity	Priority rating
	part of sets + 3 as a loose item	
Otoscope set in case	1 per consulting room, maximum 2	4
Salter scale	1 per consulting room and 3 for outreach activities	5
Sterilising drum, medium	1 per health centres	5
Sterilising drum, small	1 per health centres	4
Stethoscope	1 per qualified staff, minimum 2	5
Stethoscope, foetal, Pinard	1 per consulting room + 1 for maternity + 1 for outreach	5
Stove, kerosene, single burner	1 per health centres	5
Stretcher, foldable	1 per health centres	3
Suction pump, electrical	3 per health centres: 1 for OPD/wards + 1 for maternity ward	4
Suction pump, foot -operated	2 per health centres: 1 for OPD/wards + 1 for maternity ward	4
Suturing set	1 for OPD + 1 for wards	5
Thermometer jar	1 per consulting room, 1 per ward	3
Thermometer, digital	1 per consulting room, 1 per ward	5
Timer, 60 min	1 for wards and OPD together	5
Torch, medical, pen-sized	2 per health centres	5
Trolley, medicine	1 per health centres	4
Urinal, male	1 per 4 beds	3
Vaginal delivery/episiotomy set	3-5 per health centres	5
Vaginal speculum, large	2 per health centres	4
Vaginal speculum, medium	5 per health centres	5
Vaginal speculum, small	1 per health centres	3
Wall clock	1 for OPD + 1 for maternity ward	5
Waste bin with lid	1 per consulting room, 1 per ward	3
Weighing scale, adult	1 per consulting room	5
Weighing scale, infant, beam type	1 for OPD + 1 for maternity ward	5
Weighing trousers	1 set of 5 per salter scale (because they are sold this way)	5
Dental Equipment		
Dental chair	1 per health centres with dental therapist	2
Dental syringe	1 per health centres with 10 trained in dental care	2
Mirror set	1 per health centres with 10 trained in dental care	2
Molar extraction set	1 per health centres with 10 trained in dental care	2
Probe set	1 per health centres with 10 trained in dental care	2
Set of tweezers	1 per health centres with 10 trained in dental care	2
Upper incisor forceps set	1 per health centre with 10 trained in dental care	2
Pharmacy Equipment		

Items	Method to Calculate Adequate Quantity	Priority rating
20 ml medicine cup	2 per health centre	3
Drug cabinet, lockable	1 per health centre	4
Refrigerator, domestic	1 per health centre	5
Tablet counting tray	1 per health centre	3
Cold Chain Equipment		
Refrigerator for vaccines	1 per health centre	5
Vaccine carrier	1 per health centre	5
Vaccine cold box		5
Laboratory Equipment		
Flammable liquid cabinet	1 per health centre with laboratory	3
Autoclave, portable	1 per health centre with laboratory technician or microscopist	4
Binocular microscope	1 per health centre with laboratory technician or microscopist	5
Glucometer	1 per health centre	5
Haemoglobinometer	1 per health centre	5
Hand Tally counter	1 per health centre with laboratory technician or microscopist	3
Centrifuge	1 per health centre with laboratory technician or microscopist	4
Rapid diagnostic test for malaria	Consumable	5
RPR rotator	1 per health centre	5
Spirit lamp	1 per health centre with laboratory technician or microscopist	5
Stool for laboratory worker	1 per laboratory worker	4
Timer	1 per health centre with laboratory technician or microscopist	5
Triple beam balance/analytical balance	1 per health centre with laboratory technician or microscopist	5
Water distiller	1 per health centre with laboratory technician or microscopist and no water filter; if none is available, the distiller is preferred option	3
Water filter	1 per health centre with laboratory technician or microscopist and no water distiller, but water distiller is preferred option	3
Environmental Health Equipment		
Bucket for mixing chemicals	3 per health centre	5
Food and water sample box	1 per health centre	5
Lovibond Comparator	1 per health centre	3
Measuring jar	3 per health centre	5

Items	Method to Calculate Adequate Quantity	Priority rating
Meat inspection kit	2 per health centre	4
Personal Protective Equipment	2 per health centre	5
Rodent control apparatus	1 per health centre	3
Squirt gun	2 per health centre	3
Tape measure	2 per health centre	5
Vector control sprayer	1 per health centre	5
Water level meter	1 per health centre	5
Miscellaneous		
Camping equipment set	2 per rural health centre	2
Fire extinguisher	1 per designated area	1
Health Centre solar power supply system for light, cold chain and laboratory	1 per health centre	5
Health post/health centre maintenance kit	1 per health centre	2
Hurricane lamp	1 per ward	1

Annex 14: List of Cost Item Codes for Budget Preparation

Account Type	Sub- Head	Sub-Head title
2	1	Personal emoluments
2	2	Use of goods and services
2	3	Consumption of fixed capital
2	4	Financial charges
2	5	Social benefits
2	6	Grants and other payments
2	7	Subsidies
2	8	Legal costs
2	9	Constitutional and statutory expenditure
3	1	Non-financial assets

Account Type	Sub- Head	Item	Item Title
2	1	1	Salaries
2	1	2	Wages
2	1	3	Allowances
2	1	4	Personnel related costs
2	2	1	Office costs
2	2	2	Building, repair and maintenance costs
2	2	3	Plant, machinery, vehicle running and maintenance costs
2	2	4	Other administrative operating costs
2	2	5	Requisites
2	2	6	Services
2	2	7	Travel expenses
2	2	8	Training
2	2	9	Legal costs
2	4	3	Other financial charges
2	5	1	Social assistance benefits
2	6	1	Grants to grant-aided institutions
2	6	2	Grants to NGOs
2	6	3	Grants to households
2	6	4	Grants to institutional revolving funds
2	6	5	Other grants
2	6	6	Transfers to government units
2	6	7	Other payments
2	8	1	Legal expenses
3	1	1	Fixed assets

Account Type	Sub-Head	Item	Sub-Item	Sub-Item Title
2	1	1	1	Salaries – public service
2	1	2	0	Wages
2	1	3	1	Flexible allowances
2	1	3	2	Fixed allowances
2	1	4	1	Housing costs
2	1	4	2	Statutory contributions
2	2	1	0	Office costs
2	2	2	0	Building, repair and maintenance costs
2	2	3	0	Plant, machinery, vehicle running and maintenance costs
2	2	4	0	Other administrative operating costs
2	2	5	0	Requisites
2	2	6	0	Services
2	2	7	1	Travel expenses within Zambia
2	2	7	2	Travel expenses outside Zambia
2	2	8	1	Short-term training and staff development within Zambia (<= 6 months)
2	2	8	2	Short-term training and staff development outside Zambia (<= 6 months)
2	2	8	3	Long-term training and staff development within Zambia (> 6 months)
2	2	8	4	Long-term training and staff development outside Zambia (> months)
2	2	8	5	Registration and subscriptions (professional bodies)
2	2	8	6	Medical costs
2	2	8	7	Other costs
2	2	9	0	Legal costs
2	4	3	0	Other financial charges
2	5	1	0	Social assistance benefits
2	6	1	0	Grants to grant-aided institutions
2	6	2	0	Grants to non-governmental organizations
2	6	3	0	Grants to households
2	6	4	0	Grants to institutional revolving funds
2	6	5	0	Other grants
2	6	6	0	Transfers to government units
2	6	7	0	Other payments
2	8	1	0	Legal expenses
3	1	1	1	Buildings and structures
3	1	1	2	Plant, machinery and equipment
3	1	1	3	Office equipment
3	1	1	5	Other assets
3	1	1	7	Vehicles and motorcycles
3	1	1	8	Specialized vehicles
3	1	1	9	Intangible fixed assets

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
2	1	1	1	10	Super scale
2	1	1	1	20	Salaries Division I
2	1	1	1	30	Salaries Division II
2	1	1	1	40	Salaries Division III
2	1	1	1	50	Contractual salaries
2	1	1	1	60	Salaries – locally engaged staff
2	1	2	0	10	Wages – classified employees
2	1	3	1	10	Retention allowance
2	1	3	1	20	Special education allowance
2	1	3	1	30	Rural hardship allowance
2	1	3	1	40	Extra duty allowance
2	1	3	1	50	Local supplementation allowance
2	1	3	2	1	Cash in Lieu of Leave Division I
2	1	3	2	3	Cash in Lieu of Leave Division II
2	1	3	2	5	Cash in Lieu of Leave Division III
2	1	3	2	7	Cash in Lieu of Leave – Teaching Service
2	1	3	2	9	Cash in Lieu of Leave – Classified Employees
2	1	3	2	11	Commuted night duty allowance
2	1	3	2	13	Overtime Division II
2	1	3	2	15	Overtime Division III
2	1	3	2	17	Overtime Classified Employees
2	1	3	2	19	Commuted overtime
2	1	3	2	27	Responsibility allowance
2	1	3	2	29	Instructor’s allowance
2	1	3	2	33	Shift allowance
2	1	3	2	47	Long service bonus
2	1	3	2	49	Travelling on leave
2	1	3	2	59	On call allowance
2	1	3	2	67	Transport allowance
2	1	3	2	69	Risk allowance
2	1	3	2	71	Housing allowance
2	1	3	2	75	Contract gratuity
2	1	3	2	79	Education allowance
2	1	3	2	83	Extra accreditation allowance
2	1	3	2	99	Other allowances
2	1	4	1	60	House rentals

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
2	2	1	0	10	Office material
2	2	1	0	20	Phone, fax, telex, radio (charges and maintenance)
2	2	1	0	30	Internet charges
2	2	1	0	40	Postal charges
2	2	1	0	50	Computer and peripheral costs
2	2	1	0	60	Maintenance of office equipment
2	2	1	0	70	Machine spare parts
2	2	1	0	80	Data processing services
2	2	1	0	90	Books, magazines, newspapers , documentation
2	2	1	0	95	Insurance
2	2	2	0	10	Rentals for buildings
2	2	2	0	20	Water and sanitation charges
2	2	2	0	30	Electricity charges
2	2	2	0	40	Building maintenance (maintenance, consumables)
2	2	2	0	50	Office furniture and fittings (maintenance)
2	2	2	0	60	Insurance for buildings
2	2	2	0	70	Security and care taking charges
2	2	3	0	10	Petrol, oil and lubricants
2	2	3	0	20	Servicing (other consumables)
2	2	3	0	30	Spare parts
2	2	3	0	40	Tyres
2	2	3	0	50	Repairs
2	2	3	0	60	Insurance
2	2	3	0	70	Licenses and taxes
2	2	3	0	99	Other costs
2	2	4	0	10	Provisions
2	2	4	0	30	Meal allowance
2	2	4	0	40	Uniform allowance
2	2	4	0	50	Repatriation allowance
2	2	4	0	60	Boards and committees allowances
2	2	4	0	99	Other costs
2	2	5	0	1	Hand tools and equipment
2	2	5	0	3	Dental material
2	2	5	0	5	Protective wear, clothing and uniforms
2	2	5	0	8	Blood bank materials
2	2	5	0	10	Drugs, vaccines
2	2	5	0	13	Drugs for HIV and AIDS

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
2	2	5	0	15	Medical supplies (except drugs and vaccines)
2	2	5	0	18	Surgery materials
2	2	5	0	20	X-ray materials
2	2	5	0	23	Material and appliances for the sick
2	2	5	0	29	Insecticides
2	2	5	0	33	Veterinary material
2	2	5	0	38	Survey and mapping
2	2	5	0	40	School requisites
2	2	5	0	43	Laboratory material
2	2	5	0	45	Medical stationery
2	2	5	0	48	Water treatment chemicals
2	2	5	0	99	Other purchases
2	2	6	0	1	Consultancy, studies, fees, technical assistance
2	2	6	0	3	Audit fees
2	2	6	0	4	Accounts and audit services expenses
2	2	6	0	5	Printing
2	2	6	0	8	Advertisement and publicity
2	2	6	0	10	Technical equipment repair and maintenance
2	2	6	0	13	Transportation
2	2	6	0	18	Official entertainment
2	2	6	0	20	Public functions and ceremonies
2	2	6	0	23	Shows and exhibits
2	2	6	0	30	Accommodation
2	2	6	0	33	Expenses of boards and committees
2	2	6	0	35	Hire of motor vehicles
2	2	6	0	40	Insurance – technical equipment
2	2	6	0	45	Cultural promotion
2	2	6	0	48	Census and statistical survey expenses
2	2	6	0	50	Population and communication
2	2	6	0	53	Welfare and recreation
2	2	6	0	58	Research and feasibility studies
2	2	6	0	60	Labour day expenses and awards
2	2	6	0	63	Hire of plant and equipment
2	2	6	0	73	Medical fees/charges
2	2	6	0	75	Medical fees/charges abroad
2	2	6	0	78	Conferences, seminars and workshops
2	2	6	0	83	Bank charges

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
2	2	6	0	99	Other services
2	2	7	1	10	Road, rail and air fares
2	2	7	1	20	Accommodation charges
2	2	7	1	30	Allowances
2	2	7	1	40	Kilometre allowance
2	2	7	1	50	Petrol, oil and lubricant
2	2	7	1	60	Airport charges
2	2	7	2	10	Road, rail and air fares
2	2	7	2	20	Accommodation charges
2	2	7	2	30	Allowances
2	2	7	2	40	Kilometre allowance
2	2	7	2	50	Petrol, oil and lubricants
2	2	7	2	60	Airport charges
2	2	7	2	70	Visas
2	2	8	1	10	Training allowances
2	2	8	1	20	Training and education charges
2	2	8	1	30	Workshops, seminars and conferences
2	2	8	1	40	Road, rail and air fares
2	2	8	1	50	Other expenses
2	2	8	2	10	Training allowances
2	2	8	2	20	Training and education charges
2	2	8	2	30	Workshops, seminars and conferences
2	2	8	2	40	Road, rail and air fares
2	2	8	2	50	Other expenses
2	2	8	3	10	Training allowances
2	2	8	3	20	Training and education charges
2	2	8	3	40	Bursaries award
2	2	8	3	50	Road, rail and air fares
2	2	8	3	60	Other expenses
2	2	8	4	10	Training allowances
2	2	8	4	20	Training and education charges
2	2	8	4	30	Bursaries award
2	2	8	4	40	Road, rail and air fares
2	2	8	4	50	Other expenses
2	2	8	5	10	Registration
2	2	8	5	20	Subscriptions
2	2	8	6	10	Medical charges within Zambia

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
2	2	8	6	20	Medical charges outside Zambia
2	2	8	7	10	Other expenses
2	2	9	0	10	Compensation and awards
2	2	9	0	50	Legal fees
2	4	3	0	10	Contractual penalties
2	5	1	0	30	Social assistance benefits
2	5	1	0	99	Other social benefits
2	6	1	0	10	Grants to government agencies
2	6	1	0	20	Grants to local authorities
2	6	3	0	20	Scholarships
2	6	2	0	10	Grants to non-governmental organizations
2	6	3	0	50	Medical treatment outside Zambia (non-employees)
2	6	4	0	10	Grants to institutional revolving funds
2	6	5	0	10	Other grants
2	6	6	0	10	Funding to government units
2	6	7	0	10	Contributions to international organizations
2	8	1	0	10	Compensation and awards
2	8	1	0	30	Retrenchee claims
2	8	1	0	40	Penalties (court cases)
3	1	1	1	1	Residential buildings
3	1	1	1	2	Office buildings
3	1	1	1	3	Fixtures and fittings
3	1	1	1	5	Colleges
3	1	1	1	7	Hospitals, clinics and health centres
3	1	1	2	3	Air conditioning equipment
3	1	1	2	4	Elevators
3	1	1	2	5	Electrical and electronic equipment
3	1	1	2	6	Medical equipment
3	1	1	2	7	Laboratory and scientific equipment
3	1	1	2	10	Marine equipment
3	1	1	2	12	Solar equipment
3	1	1	2	99	Other machinery and equipment
3	1	1	3	1	Computers, peripherals, equipment
3	1	1	3	2	Communication equipment
3	1	1	3	3	Telephone, fax, telex, radio
3	1	1	3	4	Refrigerator, TV, VCR, cameras, air conditioners
3	1	1	3	99	Other office equipment
3	1	1	5	1	Office furniture
3	1	1	5	2	Residential furniture
3	1	1	5	3	School furniture

Account Type	Sub-Head	Item	Sub-Item	Sub-Sub Item	Account Name
3	1	1	5	4	Hospital furniture
3	1	1	7	1	Bicycles
3	1	1	7	2	Motorcycles ?=125 cc
3	1	1	7	3	Motorcycles? 125 cc
3	1	1	7	4	Motor vehicles ?= 3,500 kg
3	1	1	7	5	Motor vehicles over 3,500 kg ?= 16,000 kg
3	1	1	7	6	Heavy duty vehicles? 16,000 kg
3	1	1	8	1	Ambulances

Annex 15: List of Contributors

No.	Name	Sex	Position	Station
1	Vivian Njekwa	F	Data Associate	Ministry of Health - PHO, Livingstone
2	Mukuka Chanda	M	Data Management Specialist	Ministry of Health - PHO, Livingstone
3	Steven S. Mtonga	M	Financial Specialist	Ministry of Health - HQ, Lusaka
4	Killion Wanchete Ngoma	M	Health Planning and Costing Specialist	Ministry of Health - HQ, Lusaka
5	Patrick Banda	M	Senior Planner	Ministry of Health - HQ, Lusaka
6	Henry C. Kansembe	M	Chief Planner	Ministry of Health - HQ, Lusaka
7	Emily Moonze	F	Health Services Planning Specialist	Health Services and Systems Programme, Lusaka
8	Patrick M. Chewe	M	Monitoring and Evaluation Specialist	Health Services and Systems Programme, Lusaka
10	Audrey Shimuyobe	F	Registered Midwife	Livingstone District Health Office
11	Lillian M. Bwanjelela	F	Registered Nurse	Livingstone District Health Office
12	Linny Lineo M. Lubasi	F	Registered Nurse	Livingstone District Health Office
13	Theresa M. Singoyi	F	Registered Midwife	Livingstone District Health Management Team
14	Chilube A. Mungole	F	Manager Planning and Development	Kazungula District Health Office
15	Dr. Francis Hadunka	M	Acting District Director of Health	Kazungula District Health Office
16	Greenford M. Sibusenga	M	Manager Administration	Livingstone District Health Office Team
17	Dr. Kenneth Chongo Chibwe	M	Acting District Medical Officer	Livingstone District Health Office Team
18	Lee Chileshe	M	P/Planner MOH/HQ	Ministry of Health
19	Patrick Banda	M	Senior Planner/P&B	Ministry of Health, headquarters, Lusaka
20	Desmond Banda	M	Senior Planner/	Ministry of Health , headquarters, Lusaka
21	Mulonda Mate	M	Ag. DDPHR- EOH	Ministry of Health, headquarters, Lusaka
22	Wesley Mwambazi	M	P/P –P&B,	Ministry of Health, headquarters, Lusaka
23	Mumba Tembo	M	Provincial Planner	PHO: Kasama Northern Province
24	Mathew Banda	M	FMGR-PRA	Ministry of Health, Lusaka
25	Dr. Handema Ray	M	TDRC – Deputy Director	Ministry of Health, Ndola
26	Mark Musonda Sikapizye	M	Provincial Planner	PHO: Livingstone, Southern Province
27	Bruce Ernest	M	Provincial Planner	PHO: Chipata, Eastern Province

No.	Name	Sex	Position	Station
28	Muriel Syacumpi	F	Community Liaison Specialist	Zambia Integrated System Strengthening Programme
29	Anna Chirwa	F	Community Health Coordinator (CHC)	Zambia Integrated System Strengthening Programme
30	Timothy Silweya	M	Community Health Coordinator (CHC)	Zambia Integrated System Strengthening Programme
31	Danford Makayi	M	Community Health Coordinator (CHC)	Zambia Integrated System Strengthening Programme
32	Eridge Simukanzye	M	Community Health Coordinator (CHC)	Zambia Integrated System Strengthening Programme
33	Vera Mbewe	F	Social Mobilisation Advisor	Zambia Integrated System Strengthening Programme
34	Terence Muchengwa	M	Management Specialist	Zambia Integrated System Strengthening Programme